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ABSTRACT

This newsletter theme issue focuses on providing services to infants with special needs in rural areas. In "Old Threads, New Patterns: Reaching Out to Rural Families," Deborah Harris-Usner discusses bringing infant mental health care and parent-infant psychotherapy to rural New Mexico. In "The People of Kids Place: Creating and Maintaining Comprehensive Services for Young Children and Their Families in Small Rural Communities," Carolyn King describes the start-up and first 7 years of a comprehensive early childhood service center and considers the value of community input. In "Delivering Prenatal and Postpartum Care in Rural New York State," Richard Jones and others discuss issues related to transportation and access to care, hospitals in rural areas, and services at outreach sites. In "Elk in the Road, Chicks in the Foyer: Infant/Family Work in Rural Areas," Shelley Marie Windsor describes traveling to rural homes; case examples; and the need to connect rural early intervention providers with consultation, supervision, and training. In "Rural Early Intervention Training: Challenges and Strategies," Sue Forest discusses strategies for professional education as well as competencies needed for working with rural families and their infants and toddlers, child assessment, program planning and evaluation, and community service delivery. (SW)

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[Working with Infants, Toddlers, and Families in Rural Areas]

Emily Fenichel, Ed.

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Barbara Young

Old Threads, New Patterns:

Reaching out to rural families

Deborah Harris-Usner, MSW, LISW

Las Cumbres Learning Services, Española, New Mexico

Bringing infant mental health care and parent-infant psychotherapy to rural New Mexico was not exactly my intention when I returned to the state in 1987 after completing graduate school. As an intern at the Infant-Parent Program (IPP) at San Francisco General Hospital, I had become a convert to this relatively new mental health field, and my enthusiasm ran high. I planned to introduce my newfound inspiration in Albuquerque, where I thought I could garner support for the concept of infant mental health care and psychotherapy with parents and their young children. I had no idea that I would eventually bring these concepts to the rural communities in the northern part of the state.

My tenure at IPP had been an incredible learning

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Editor's Note

This issue of Zero to Three is about working with infants, toddlers, and their families in America's small towns and rural areas. Contributing authors describe in rich detail the rewards and challenges of working with individual young children and families; creating and maintaining services adapted to local needs; and finding ways to nurture their own and their colleagues' professional development.

A confirmed city dweller myself, I expected that the articles in this issue would describe a totally unfamiliar world. In fact, I kept recognizing common ground. The barriers that keep rural children and families from care — lack of telephones and transportation; fragmented services and extremely limited mental health expertise; cultural mismatches; and generally inadequate resources — are often the same ones (although in different form) that challenge families and service providers in inner-city neighborhoods. And professional isolation can be as painful for the single "baby person" in a large bureaucracy as for an infant/family practitioner who is physically remote from supportive, knowledgeable colleagues.

Just as families and providers in city and country face many challenges in common, so we can all benefit from the lessons learned, and shared so generously in this issue, by Deborah Harris-Usner, Carolyn King, the A.O. Fox Hospital Maternal Care Program team, Shelley Marie Windsor, and Sue Forest. Their resourcefulness, creativity, and perseverance are inspiring.

Emily Fenichel, Editor

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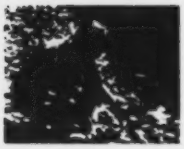

Old Threads, New Patterns

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experience, mostly because of the excellent supervision and mentoring I received from experts in the field. I was fortunate to work with the program that Selma Fraiberg started (Fraiberg, 1980), and I opted to intern there a second year and to continue my training after graduating. Feeling fully primed with ideas and inspiration, I naively anticipated that I simply would recreate such an ideal situation in New Mexico, where I had previously lived for ten years.

So, I packed my belongings and my optimism and headed back to Nuevo Mexico, the Land of Enchantment, where I envisioned establishing a southwestern version of IPP. Four years in Albuquerque, New Mexico's biggest city, provided me with much valuable experience, but I found that even in that large urban area, no one was ready, financially or conceptually, to support my ideas. In 1991, I moved back to the rural, northern part of the state (which had been my home before graduate school), where I finally saw an opportunity to bring my dream to fruition.

Ironically, I found that innovation is sometimes easier in rural areas. Despite a lack of funds, resources, and professional staff in rural areas, new ideas are easier to initiate and meet with less resistance, perhaps because there are fewer bureaucratic hoops to jump through. An agency in a small town was anxious to have me start a program.

However, I soon ran into challenges and had to adjust my concepts of what an infant mental health project should look like. Three and one-half years later, my ideas continue to evolve to meet the special needs of the population that I serve. In the small town of Española, I faced starting a program with few resources and no colleagues with whom I could consult. This demanded an adaptation of the approaches I'd practiced in urban areas. As I grew acquainted with this new setting, I realized that the area's unique circumstances and idiosyncracies would require a program with a very different character. This article describes my experiences as an "infant mental health specialist" in an early intervention program in rural northern New Mexico.

The Land of Enchantment

New Mexico is primarily a rural state, with a total population of only 1.5 million — less than one quarter the number of people in the San Francisco Bay Area — although the census has grown dramatically since I first moved here almost twenty years ago. Unlike California and many other parts of the United States that are experiencing a tide of new arrivals from other countries, New Mexico's immigrant population consists primarily of people from large cities. These mostly upper- and middle-class Anglo newcomers are pulled to New Mexico to trade their hectic urban lives for the perceived tranquillity and very real beauty of the Southwest. The resident population, by contrast, consists of Native Americans and Hispanics who are struggling to maintain their traditions and social systems while adapting to a rapidly changing cultural and physical environment.

Española is situated in the heart of Northern New Mexico and functions as the hub and service center for Rio Arriba county. This huge county encompasses an area of 5,856 square miles, of which only 4.7 square miles constitute the town of Española. In 1980, the population of Rio Arriba County was 29,282. The county comprises Pueblo, Navajo, and Apache reservations as well as a multitude of small Hispanic enclaves and mountain villages; some Native American land here has been settled for at least 800 years, and some Hispanic towns were founded nearly 400 years ago. The landscape and light create stunning panoramas that have inspired artists and drawn them to this unique area since the early 1900's. But harsh statistics paint another picture, one which tourists and artists don't flock to see. Children in the birth-to-five age group constitute 23 percent of Rio Arriba's population. Forty percent of family households presently live in poverty. Since 1980, Rio Arriba County consistently has ranked either fourth or

Dorthea Lange, Farm Security Administration, 1939

fifth in New Mexico (itself one of the four poorest states in the US) in terms of poverty. A third of all mothers in the county are younger than 19. Each year, 6.8 percent of all live births are to teenage girls. Fifty-seven percent of all household heads with children under the age of eighteen are women. Forty-five of each one thousand births are to unwed females (US Census 1990).

Violence in many forms is commonplace in Rio Arriba; a male between the ages of 15 and 44 is more likely to die at the hands of a gun, a bottle, or a needle, than anything else. For every 100,000 youngsters, ages 15 to 19, there are 169 violent deaths each year. From 1987 to 1991, the rate of child abuse in the Rio Arriba area increased from 31 to 52 incidents per year per 1000 children, and the county ranks highest in the state for abuse and neglect investigations. Only 35 percent of expectant mothers in the county receive prenatal care. The litany of grim statistics goes on and on. They combine to portray a region in great turmoil. The social fabric of these rural communities is unraveling at an alarming rate. The strands of this once tightly woven rug — living off the land, self-sufficiency, and reliable support provided by an extended family — are breaking and being replaced by hard drugs, alcohol, poverty, abuse, violence and desperation. Many people are struggling to make sense of the changes. The older people often feel bewildered and helpless as they watch their children stumble and fall and their powerful extended family systems erode away. The next victims are the infant children. Frequently grandparents step in to lend a hand or foster babies. More often, however, the parenting is done by young and emotionally wounded mothers and fathers.

Needless to say, many young children in this area grow up in multiproblem families, and they are at high risk for developmental, emotional and behavioral problems — and services are woefully inadequate. The State of New Mexico ranks among the lowest in mental-health care funding, the greater part of which is channeled to urban centers. Most qualified and competent professionals also end up in the cities — primarily Santa Fe and Albuquerque. Few clinicians are willing to work in the remote, rugged, and sometimes hostile conditions of rural New Mexico. Customs and language barriers often discourage clinicians, as do low salaries and extraordinarily high case-loads. Few therapists and service providers last long in these circumstances. Many burn out and go to the nearest cities for more lucrative work. Besides draining the area of skilled personnel, this continual exodus of case workers and clinicians makes it difficult for families to build trusting and therapeutic alliances.

It isn't only mental health services that are lacking in rural northern New Mexico. A sizable portion of the population in Rio Arriba lives without basic conveniences such as plumbing, running water, heat, telephones, paved roads, road maintenance, or transportation, either personal or public. Most villages lack even a system of road signs and addresses. While these conditions create a "charming and authentic" rural atmosphere that attracts outsiders wishing to see or buy a piece of "real" New Mexico, they pose special challenges for poor, isolated families and for the practitioners trying to serve them.

I took my new job at Las Cumbres Learning Services (LCLS) not long after moving back to the heart of this region of small communities and pueblos. I've since discovered the advantages and challenges of living close to my clients. Residence here keeps me in touch with the conditions that young children and their families face. I believe this provides a practitioner a certain level of acceptability. Rural people are more likely to welcome full-time residents as part of the community. At the same time, I've found that making this my home gives me a vested interest in strengthening the community. I believe such participation is especially important in northern New Mexico. Practitioners who are committed to their work and remain for long periods of time are for the most part either native residents or transplants who have solidly taken hold in this high desert terrain and now call it home.

For many of the people in northern New Mexico, English is a second language. Spanish and Tewa are primary for these families. This presents another challenge for the practitioner from outside either ethnic group. A colleague was incredulous after hearing me present my work at a multicultural conference. "I don't understand how you can get away with working up north without being fluent in Spanish," she said. But I've found that the language barrier can be breached. Humility (and sometimes a little chutzpah!), a desire to learn from different cultures, an ability to observe without assumptions, and a sense of humor give you a list of the qualities that make for an effective mental health practitioner in northern New Mexico. (A good sense of direction helps too!) Although it is best if service providers speak the native language, this handicap has not prevented me from doing my work.

Educating myself

Las Cumbres Learning Services is a non-profit agency that specializes in programs for children and adults with developmental delays or disabilities. Before I arrived, services did not include mental health care or counseling, which were generally lacking for the whole region. My job was to create a new program that would bring together the existing early intervention program and infant-parent mental health and to provide child and family therapy for the community. What started as a part-time job for myself evolved into a full-fledged mental health program, including a therapeutic preschool, for children and families, with eight full-time positions, a clinical coordinator, and student interns.

But before I could accomplish my dream of creating the program, I needed to start with education—both for myself and for the agency's team of early childhood interventionists. I realized this during my first staff meeting when I introduced myself as a therapist and everyone asked me, "What kind?" In each of our worlds, "therapist" had a particular meaning. To me, it referred to a psychotherapist and more specifically to an infant-parent mental health therapist, but I was joining an agency where the long-standing and highly respected team comprised occupational, physical, and speech therapists, as well as very skilled early interventionists. My arrival instigated a new dialogue — a rewarding and enriching exchange that allowed all the therapists to expand the horizons of our work with infants, young children, and their families.

I learned about sensory integration problems and how they might affect a child's capacity to relate, about working with brain-damaged babies and premature infants with significant developmental delays. My colleagues learned what infant-parent psychotherapy means, and why building relationships with families is essential for all work with children. They also began to see that psychological factors often underlie particular problems confronted by children and families, such as attachment disorders and abuse. This exchange and expansion of knowledge continues for the entire team as we join forces to provide assessments and services to infants and families from all over northern New Mexico. The staff's commitment to consulting with and supporting each other despite the workload is inspiring.

Barbara Young

Professional issues

Because of our isolation from the mainstream of academia and practice, information about cutting-edge research is often slow to arrive, and conferences and trainings are seldom accessible or affordable for our staff. I offered my colleagues some new information about psychotherapy (and I have shared *Zero to Three* with many professionals and agencies in northern New Mexico), but although I believe that cross-training and transdisciplinary teaming is an excellent model for staff development, I felt that consultation was needed from experts to present family-provider relationships (Kalmanson and Seligman 1992) and infant-parent mental health concepts (Seligman, 1993) to the team. Consequently, we invited Stephen Seligman from the Infant-Parent Program to do a training at our agency. I asked several other agencies from Santa Fe (30 miles south) to join us as well. The presentation so inspired the participants that the attending agencies decided to form a networking committee. We now meet monthly to share resources and consult with each other in an effort to mitigate isolation and prevent burn-out. In the absence of colleagues or mentors from the same discipline at work, such contact has been a responsive voice in the wilderness when at times I felt no one understood what I was trying to do.

Happily, I have survived the first few tough years. Infant mental health has a foothold in this place so desperately in need. My early fears and loneliness have been replaced by a solid and dedicated group of colleagues — not outside experts, but local agency staff who have become interested in the integration of mental health and early intervention. Together we learn and grow and become mentors for others in this rural area. Particularly exciting is the growing Mi Hijita/ Mi Hijito team of practitioners.

Program development

In my first months at LCLS, I tried to develop a program that would convey my vision of infant-parent psychotherapy. We developed and obtained a grant specifically to serve "high-risk" infants and toddlers and their families who were not already being served — i.e., those at risk of developing emotional/psychological disturbances. We christened the new program "Mi Hijita/Mi Hijito," affectionate Spanish terms meaning my little daughter/ my little son. As used in New Mexico, the best translation is "my little dear ones." Now I began to combine my past experiences to create some-

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thing that would serve a number of needs. What evolved was a program using both group work and individual therapy.

There is no replacement for individual/infant-parent psychotherapy. But I soon realized that, in addition, working in groups was essential for several reasons. Economics was a primary factor, as I was the only psychotherapist in the agency and one of the only trained infant-parent therapists in the area. I could not see all our clients for individual sessions and, given the huge county and extensive distances between clients, visiting everyone at home each week was impossible. In addition, group meetings served the purpose of breaking the isolation of rural living. The group provided a supportive place for parents to share their experiences and make contacts, and it also created a time and context for parents to observe their own and others' children. In the group, parents could try out new behaviors and watch how others handled difficult situations with their children. After a few sessions, I realized that the group in many ways simulated the healthy aspects of traditional child-rearing styles in the extended family.

Gradually, the format for the group sessions emerged. Our meetings are structured so that during the first hour parents and children are together, focusing on interaction and observation. During the second hour, the parents come together for a therapy/psycho-educational group while the children stay together in a play therapy situation. Individual sessions are scheduled independently of the group time. Videotaping and developmental assessments are also part of the program.

Educating the community

The next step was to get the word out to the community about the Mi Hijita/Mi Hijito program. I began by contacting all the local family-oriented agencies. Although some agencies were new to me, the state is small enough that I inevitably ran into some familiar faces. Less familiar were the Native American Pueblos, who have their own social service system and tribal courts as well as their own hierarchy of protocols. I was not entirely unfamiliar with these structures, having lived and worked in the state for so many years and having had a number of Native American clients from different tribes. I presented my program first to the child protective team from one of the northern Pueblos. We met in the tribal court room, which in itself was humbling: large, solemn pictures of tribal chiefs filled the walls, and the room was very quiet and austere. I was aware that I was in a formal place and about to speak a language that would be foreign to my audience. A few unintended gaffes on my part helped to break the ice. My mistake of unwittingly parking in the tribal governor's parking space led to an announcement that the car must be moved or it would be towed. My hurried departure for the parking lot brought a few subtle chuckles and smiles behind bowed heads. After I returned and began to explain the Mi Hijita/Mi Hijito program, I spoke of Selma Fraiberg and her classic article, "Ghosts in the Nursery" (1975). Looking surprised, one man stopped me and asked, "Did you say her name was Selma Frybread?" I had no way of telling if this was a joke, a misunderstanding, or a psychoanalytical metaphor in which Fraiberg's nurturing work was being translated into the local Native American staple, frybread. He gave no indication of his intention, remaining impassive except for a mischievous twinkle in his eyes — but we all relaxed.

By the time I finished my talk, I felt the message had come through: our program works with parents and their young children in a way that supports the family in their own community, and with respect for their culture. And my intuition was confirmed when the Pueblo referred many families to the Mi Hijita/Mi Hijito program in the following years.

Reaching the families

Our next task was to inform individual families about the Mi Hijita/Mi Hijito program. I never find it easy to explain to families what infant mental health is, or what psychotherapy can accomplish. It's especially difficult here, where many families live in a world very different from mainstream America or even an impoverished, high-risk, city environment. "Counseling" or "early intervention" are not common words or concepts. Failure-to-thrive, attachment, trauma, cerebral palsy, delays, retardation — these unfamiliar terms come from another culture, and another language. Other barriers arise from social customs. For example, in the Pueblos and among traditional Hispanic families, family problems are kept private or taken to a traditional healer in the community. Talking about problems to outsiders is not an accepted practice.

The final and most critical aspect of reaching the community, of course, comes through word-of-mouth from clients. By making sure that clients feel safe and accepted for who they are — both culturally and as individuals — we have earned a positive reputation. This reputation traveled fast despite the lack of telephones and computers in our area, for like most rural communities, the small villages have well-developed "hot-lines" along which news travels faster than on the information superhighway. The proof is in the record number of referrals received this year through word-of-mouth.

Wearing many hats

One of the first questions I asked myself when I began the program was, "So what was my role in this difficult environment?" Doing this work involves stepping out of a traditional psychotherapy mode to work with fam-

ilies in a sociocultural context. It takes persistence, juggling roles, and a flexing of boundaries — and lots of back-road driving in a pick-up truck. It also brings up many new opportunities and problems.

I often perform multiple roles with clients outside of my position as the infant mental health therapist, expanding it to include many other functions. This is necessary in a rural area with limited resources. I don't think that families experience this multiplicity as dissonance (perhaps not as much as I used to feel it, anyway). One often needs to wear many hats, and my experience has shown me that families accept and often expect this. It seems to be in sync with the way people in this community share roles and perform many tasks themselves. This is not to imply that boundaries shouldn't and don't exist. To the contrary, failing to set limits and presenting oneself as everything to everyone is not healthy. Nor is sharing too much about one's own life. Every action/interaction must be considered in the context of what is therapeutic and safe.

Home visits, for example are important in our program. They make services more accessible to families, but also leave the clinician open for close scrutiny. During home visits, I've found that families are curious about me. They want to know where I live, who I am married to, and what my family connections are. I do not answer the most personal of questions, but in northern New Mexico, not all of them can be appropriately "reflected back" in psychoanalytic style. In this area, certain social mores govern the exchange of personal information. In this predominantly Hispanic and Native American rural culture, the opening discussion makes one part of the community and gives credence to a shared commitment to being here.The scrutiny brings legitimacy, a way for locals to place an unfamiliar person in the social fabric of the region. It satisfies a need for familiarity, thereby creating an opening for more sensitive subjects. These are the positive aspects of being closely associated with one's community of work.

Sometimes the experiences are less comfortable and take getting used to, such as running into clients in town —at the post office, farmer's market, drug store, doctor's office, or at community events, even funerals. There is no way to remain anonymous in a small, rural town. Colleagues born and raised here have many connections. This delicate factor must be taken into consideration when assigning cases. Complications also arise because I am often treating multiple members of one large family who are enrolled in different programs at our agency. I may be the primary therapist for all family members. Difficult situations also come up when Social Services places foster children with close relatives in the extended family. These unique situations require extra efforts concerning confidentiality, and they present some new frontiers for what Seligman and Pawl (1985) have called The Working Alliance.

Other aspects of small-town dynamics come into play. The town and Pueblo peoples have strong alliances, large extended families, and old feuding factions. It is challenging to keep track of the large webs of relationship and to remain in a position of non-alignment with the various camps, but it is important to stay cognizant of these factors. The issues often become fuzzy and the work delicate, calling for creativity and flexibility.

The educational process therefore becomes a mutual one — and one of rich rewards. Being invited to Feast Day and dances by a Native American family does not breach therapeutic boundaries, but rather represents a gesture signifying the family's pride in their ceremonies and an extension of welcome, their acceptance of me into their lives. I interpret the invitation to mean, "Come experience the spiritual importance of our world, as we have shared other parts of our lives with you."

The Cardozo family

One of the families that became involved in the Mi Hijita/ Mi Hijito program and with the Las Cumbres Early Intervention Program provides an example of how our work in this area often proceeds. My experience with the Cardozo family illustrates issues and complications that face mental health workers in culturally traditional, rural areas.

"I just heard about your program and I want to refer a young mother that I am very worried about," said the nurse calling me from the small Española hospital. "She is sixteen years old and has a one-and-a-half-year-old son and a baby girl, two months old." The nurse continued to tell me more about the Cardozo family, explaining that Angela had received no prenatal care for either of her children. She said that the new baby's extreme fussiness was causing this teen mother great distress. The nurse also felt that Angela was depressed. She, her 17-year-old boyfriend, Ed, their two children, and Ed's alcoholic father lived together in a small, isolated mountain village, approximately 20 winding miles from Española. When I asked how I could contact the family, the nurse replied, "Well, they don't have a phone and they don't have an address. In fact they don't have transportation — they get rides in to town when they can. All I can do is tell her about your program the next time she comes in and hope that she contacts you."

I was very concerned about this young mother, but I felt helpless. I waited..... and waited... for a year. Then a call came from Children's Protective Services (CPS). The situation described in the referral sounded familiar to me; yes, this was the same family. Both children had been removed from the home approximately six months ago following allegations that Julie, the infant girl, was suffering from Shaken Baby Syndrome. The current social worker (one in a series) told me that this was a "complicated" case. (I didn't tell her that we don't take any other kind!)

She felt that the young parents were very sincere and concerned about their children's welfare. They appeared earnest in their desire to reunite their family and truly ignorant about the shaking, which Angela acknowledged having done once, thinking that it would stop the baby's continual cries. Angela

and Ed had previously taken Julie to a *curandera* (healer) because they were worried about her puzzling behavior. But after she had a seizure, they rushed her to the hospital, where she was intubated. Julie was then transported to the University Medical Center in Albuquerque, approximately 100 miles south of Española — the only medical facility in the state equipped to handle pediatric emergencies. Julie had been hospitalized for two months, then placed directly into a foster home north of Española, while her older brother, Ed, Jr., was placed with Ed's mother in a community 15 miles north of Española. Angela and Ed lived 20 miles east of Española, and there was no direct route from their village to either foster home. These distances created impediments for both the family and workers.

The CPS social worker referred the family to the Mi Hijita/Mi Hijito program. She gave me a message telephone number — but the grandmother spoke only Spanish, and I wasn't sure whether my message would reach Angela and Ed. Two months later a young, attractive woman walked into my office and introduced herself as Angela. I had been anxious to hear from her, but I've found that sometimes the more formal American standards of time, which don't always apply here, must be set aside for the sake of making contact.

Thus began an intensive and multifaceted intervention that has lasted well over a year and continues today. The many players include myself, a physical therapist, an occupational therapist, an early interventionist, and a vision therapist. Programs include the Las Cumbres early intervention team, Mi Hijita/Mi Hijito, and a number of other programs administered by the state. Most of these services are coordinated to continually assess and meet the needs of the baby, Julie — not necessarily the family's needs. And because there are so many parties involved — each with different opinions, priorities, and availability, and each located in different parts of the county — the coordination process has been at times difficult and frustrating.

Shortly after Angela's first visit, Angela and Ed came to the office for their intake evaluation. Very shy and soft-spoken, they impressed me most, at first, by their youth — parents of two at age 17 and 18! They told me that their story began when Angela, then 14 years old and seeking an escape from her alcoholic mother and memories of her sexually abusing father, fell in love with Ed and moved in with him and his father. Ed's mother had moved out and divorced her husband because of his drinking, but Ed stayed because he regarded the old adobe house as his home and felt that the house was especially important since he had a baby on the way. When I once questioned the couple about staying with Mr. Cardozo, Ed replied, "Someday the house will be mine, and it is all we have" — a poignant statement about the human geography in this area. Owning a piece of land is of tremendous importance to people here. The land has been handed down for generations and often is all that remains for the next generation from a proud and self-sufficient era. Unfortunately, even this last precious legacy is being lost to the impoverished rural community.

Angela and Ed told me that when Julie had become very ill, they took her to the local hospital. Then the whole world seemed to crash around them. Not only was their infant hospitalized for two months in a faraway city and then placed in a foster home some distance away, but their little boy was also removed from their care. Angela and Ed were granted two visits a week with Ed, Jr. and one visit each week with Julie. They were both eager to increase their visits and work towards reunification. Angela, Ed, and Ed, Jr. joined the Mi Hijita/Mi Hijito group, and Angela began to see me for individual therapy as well.

Angela's overwhelming desire for support and understanding quickly opened floodgates of feelings. Isolation and tension with her own family had left Angela without a support system. Angela had raised herself, kept a relationship with Ed together for four years, and was determined to parent her two children as best she could. This did not mean it was going to be easy, or that everyone was impressed by her. Many obstacles stood in the way to reunification. For example, Angela had no driver's license and couldn't take the test in an uninsured vehicle. The state had taken Ed's driver's license away because his car was uninsured. Insurance costs money, of course, and even gas money was scarce for this couple. To earn money in a rural community, a car is essential. A car is also essential if one is to attend mandated appointments. Ed did drive illegally, but the car itself was unreliable. To get to her individual appointments, groups, and visits with the children, Angela had to beg rides from relatives and neighbors. And each missed visit with one of her children constituted a strike against the parents. The family's frustration was enormous.

Every visit, meeting or session involved a major transportation and communication effort. Phone messages left with relatives were seldom given to Angela. Winter weather conditions presented continual hazards for driving to and from their home. But despite these difficulties, the couple participated in home visits, attended sessions on a regular basis, and developed a healthier relationship with their son. Fortunately, they lived relatively close to Las Cumbres. We find it much more difficult to provide infant-parent psychotherapy to the many families in Rio Arriba County who live at a greater distance.

After seeing Angela and Ed's progress in the Mi Hijita/Mi Hijito program, CPS staff and the foster parents still expressed doubts about Angela and Ed's ability to assume full responsibility for the specialized care and monitoring that Julie needed. In the foster home, a full-time nurse helped with daily care, and Julie also received home-based occupational, physical, and vision therapy. Angela and Ed had never been a part of these sessions, as they took place in the foster home during the week and visits with Julie took place on the weekends. CPS and the foster parents worried about the isolated location of the parents' home, the distance from medical help, the unreliable sources of transportation and phone contact, and the lack of indoor plumbing. The realities of rural living severely hindered this family's ability to advance through the child protective services system and even to receive the services designed to support and monitor their progress.

Angela and Ed are an exceptional couple. In spite of the difficulties they face, they continue to make progress in all areas of their work. Angela took the "good" parenting that she was receiving individually and in the group and transferred it

not only to her own children but to other toddlers in the Mi Hijita/Mi Hijito group as well. Often she was surrounded by little children who wanted her to read or play with them. She excitedly shared this experience with her CPS caseworker, who told me, "Angela was so excited about the children being drawn to her; she said, 'I must have been enchanting.'" It was exciting to watch this shy, self-conscious girl blossom into an active participant and proud parent. Through psychotherapy, both Angela and Ed felt increasingly empowered. Continually plagued by system inadequacies, poverty, and the hardships of rural life, they persevered nevertheless.

Eventually, the team coordinating Julie's care allowed Julie to attend the weekly Mi Hijita/Mi Hijito group with her mother, although some on the team voiced hesitancies. Even after approval was secured, the treatment plan almost foundered because of logistical problems. Who was to transport Julie? Would Angela be able to get rides on time, and if appointments needed to be rescheduled, how would the agency make contact with the parents? Everyone rallied to the challenge. We mapped out plans, back-up plans, and plans for communicating messages about when to use the back-up plans. The complexity of our logistics rivaled that of some military operations.

Angela now set out to get as much hands-on experience and knowledge as she could about Julie's care. Therapy sessions were all videotaped so that Angela and Ed could review them at home. (Most rural households do have a television and a VCR, even if there isn't money for a satellite dish to receive regular television broadcasts. Videotape has become a wonderful medium for getting information to isolated families.) At a team meeting six months after Ed and Angela began their treatment program with Julie, the CPS staff member was now willing to increase visits and allow Julie to visit her parents in their home. This plan created a whole new set of logistical nightmares regarding transportation, re-arranging schedules to provide services at Ed and Angela's, getting a nurse who would now go to their house. Just getting messages back and forth could take several weeks. A trip to the Cardozos' home wouldn't guarantee contact, as they were often out cutting wood or doing odd jobs.

In time, Julie was allowed to go home four days out of each week. Angela demonstrated an uncanny awareness of her daughter's skills and needs. She watched the therapists closely and they jokingly said that she will soon put them out of work with her adeptness. Everyone was impressed with her skills and appropriateness with both her children.

Angela continues to try new approaches with Julie and notes each area of progress in movement, sight, or communication. In fact, she has recently requested that a speech therapist come to her home. My role has lessened with Angela as all the other therapists have entered her world. Julie has a nurse several days of the week and at least four other providers who make the trip to her home on a weekly basis. She has an extended family of infant specialists, and she is quite happy to have them in her little mountain adobe home.

It is worth noting that it was Julie's physical disabilities which provided the "ticket" to maximum services and support for the Cardozo family. In New Mexico, as elsewhere, babies and families facing "only" emotional or environmental risk factors do not have access to the funds or services available to infants and young children with physical disabilities or developmental delays.

Angela no longer attends the Mi Hijita/Mi Hijito group, but she recently wrote me a note and sent it with the early interventionist: "Dear Deborah, I am doing great but I think it would be good to check in — when can we meet?" I sent a note back and went for a home visit the following week. I found Angela and her two children at home; Ed was out cutting wood for the winter. Angela was aglow with her new discoveries about Julie — and Angela was truly "enchanting." As we sat by the wood stove in the darkening house that evening, I thought of how much she had matured and taken events into her own hands. Angela told me about her plans to get her driver's license and her wish to start weaving again, something she can do at home to earn some money. Weaving is one of the oldest traditions in this area, and local weavers are employed by a number of tourist shops. In this case, the old tradition was helping to support a new family.

I won't continue to see Angela frequently, but I remain available when and if she needs me, and the line from our agency to Ed and Angela's home is solidly connected. As the years pass, I am sure I will see Angela and her family informally. Our villages are along the same stretch of road, about ten miles apart, which in this area practically makes us next door neighbors.

My hope is that we at Las Cumbres and colleagues across the country can work toward providing infant-parent mental health care, as well as early intervention services, to children and families who need it, regardless of where they live. Rural families need services, as well as goods, to be readily accessible, so they can "stock up" on them when they journey to town. What we deliver in home visiting can be supplemented by providing as many services as possible under one agency roof — not unlike the old general store model, where folks came from miles around to get all their supplies. Families have come to trust our staff, and the more comprehensive and continuous a care model we can provide, the more needs we will meet for the children of rural Northern New Mexico.

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The People of Kids Place:

Creating and Maintaining Comprehensive Services for Young Children and Their Families in Small Rural Communities

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Jeffersonville, Indiana

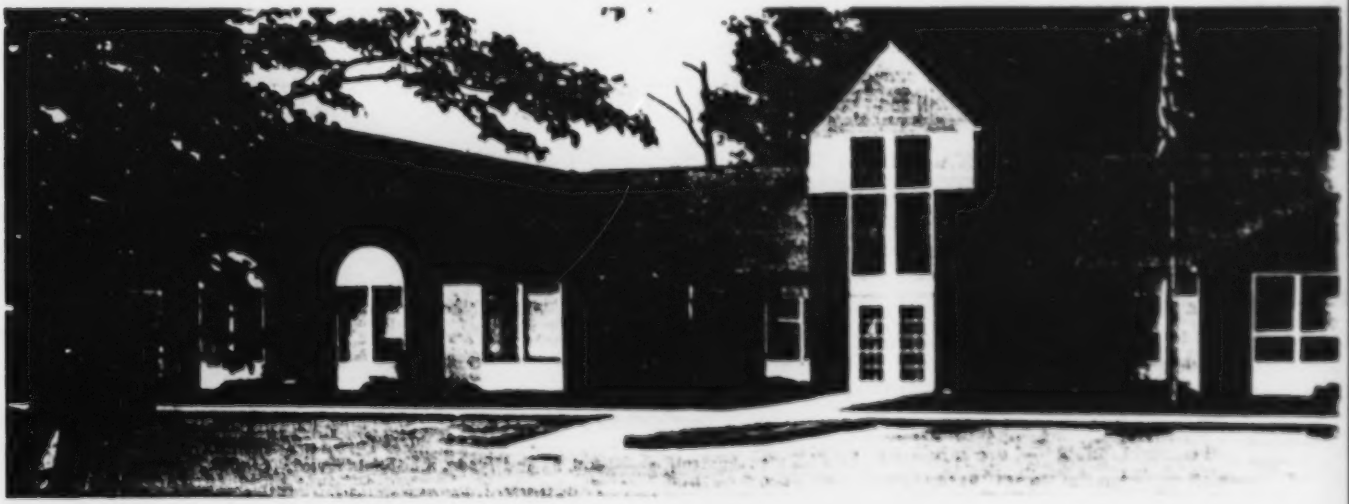
Pam Pecord lived longer than might have been expected for someone born with cystic fibrosis. She was 38 years old when she died in February, 1995, in Scottsburg, Indiana, a town of 20,000 where she had lived for many years. Pam's funeral was a celebration of her life. Friends who attended talked about Pam's involvement in the creation of Kids Place, a comprehensive early childhood center in Scott County. We remembered the Chamber of Commerce meeting in 1986, when Pam and John Pecord (who had decided not to have children of their own because of the genetic nature of Pam's disease) decided that, through Kids Place, they could make a difference for all the children in their community.

The vision that inspired Pam and John Pecord was of a place in Scott County where families and children could get a variety of services under one roof. In 1986, an earnest, but somewhat unfocused group of visionaries shared a belief that a long-term cycle of underachievement by many Scott County children could be broken by building a high-quality, collaborative service center accessible to all families. Our committee was made up primarily of parents and staff of an agency called New Hope Services, which provided programs for preschoolers with special needs and their parents. No one on the committee held a position of wealth or power in the community, but we were determined to raise $125,000. This was the amount needed to convince state legislators to grant an additional $375,000 from state capital project funds to the building effort.

The first time that the Pecords met with the Kids Place committee, we sat on painted wooden preschool chairs in a run-down church annex basement slated for demolition. Pam and John listened somewhat skeptically. After the meeting, the Pecords did a little surreptitious checking around about the viability of New Hope Services. Then they committed themselves to play a key role in the development of Kids Place.

Over the next 18 months, Northside Grocery (the Pecord family business) became a hotbed of activity as command center for Kids Place. Northside was a "mom and pop" grocery store, where Pam and John worked long hours, seven days a week. Their whole staff became indoctrinated with the Kids Place vision and immersed in the project. Before long, the telephone was as apt to ring about the latest Kids Place donation as it was about a produce order.

In a small community, news travels by word of mouth. Customers of the Northside Grocery (which also served as a lunchtime deli) reflected a cross-section of the community, from local politicians to residents of a nearby public housing unit. Pam and John used every opportunity to tell their customers the latest news about Kids Place. Pam used her considerable skills as a graphic artist to create posters, flyers, and silk-screened

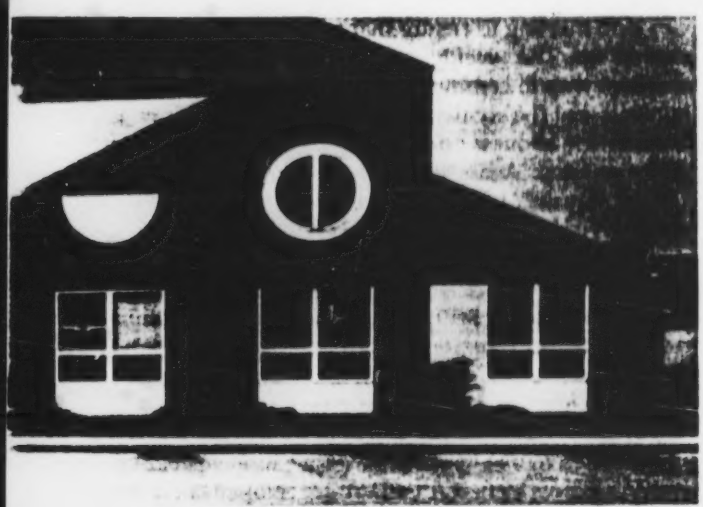


attire for Kids Place fundraising events. In the spring of 1987, she and John donated hours of their own time, the time of Northside staff, food, and prizes to make the first annual Kids Place Festival on the Square a huge success. People from every part of the community came to the booths and games and raised several thousand dollars "for our children."

Local merchants and county officials had a hard time turning down a request for help with Kids Place when it was Pam who asked. Her positive outlook and relentless effort in spite of the constraints of her condition inspired other people. The momentum for Kids Place grew. More volunteers participated. Donations came pouring in. Eventually, the community raised more than $150,000. We made a triumphant presentation to the state legislators in Indianapolis, who voted unanimously to award the construction grant for Kids Place. At the groundbreaking ceremony on May 12, 1988, Pam and John proudly helped turn a shovel. Pam was later honored for her efforts by the Pilot Club as "Handicapped Woman of the Year."

Kids Place: The first seven years

The goals of the initial Kids Place visionaries have been met and have exceeded our furthest expectations. Located on SR56, a major state road, the Kids Place building looks like a stack of brightly colored children's blocks. Since 1988, Kids Place has provided services to over 80 percent of preschoolers in Scott County. The county's first licensed child care center is at Kids Place. In 1991, the state Maternal and Child Health project funded a well-child clinic at Kids Place; the clinic now serves sick children as well. School-aged child care and teen parent programs have been spawned through Kids Place. Children from birth to five years with special needs, whose families often had to drive them 35 miles for therapy, can now get all the services they need at Kids Place.



School officials tell us that children and parents who have participated in early intervention programs at Kids Place are coming to school empowered and ready to learn. Overburdened, single-parent families report that they would be lost without Kids Place to provide support, parent education, and encouragement.

An additional Kids Place is scheduled to be built in the northern part of Scott County. This center, in an area with high teen pregnancy rates and a low percentage of adults with high school diplomas, will focus on infant care and family literacy programs.

Emulating Kids Place

Kids Place has been so successful in Scott County that many other communities in Indiana want to emulate it. Since opening Kids Place, New Hope Services has built three similar centers in nearby Clark County. Each center was planned and funded through a cooperative effort with local government officials, community businesses, service recipients, and not-for-profit agencies. In each small community, a group of committed citizens have caught the vision and worked to raise the funds needed for child and family centers. In addition, the Indiana State Department of Commerce, which has allotted a certain percentage of its Community Focus Funds to child care settings in small communities, encourages the Kids Place concept. Commerce Department staff realized that business benefits when child care centers offer a variety of services, such as immunization clinics, W.I.C., and therapy for children with special needs. Parents don't have to miss work to take their children to different sites for services.

In 1992, Kids Station opened in Borden. Kids Station operates on a smaller scale than Kids Place, but offers many of the same programs — Head Start and child care for children 3-5 years of age and home- or center-based early intervention for children under three. A special United Way grant funds parent education and individual counseling for families in this hard-to-access community. Traveling WIC counselors and immunization clinics come to Kids Station on a regular schedule. In January, 1994, Kids Square opened in Charlestown. All programs are already operating at capacity — these include child care (provided by the local YMCA), a Head Start classroom, WIC and well-child clinics, and early intervention and family support programs operated by New Hope Services.

In June, 1995, Kidsville will open in Clarksville. Kidsville will provide child care for infants through six-year-olds, Head Start, and family support programs. We have established a partnership with a home for teen parents to reserve child care slots and job training opportunities for their residents and also hope to offer weekend play groups for non-custodial parents of preschoolers.

Sixty percent of participants in all these new programs are low-income. Once new centers are built, local

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committees actively pursue state subsidies and other funding sources to make programs accessible to all who need them.

Community involvement and collaboration

Our programs attempt to be responsive to the identified needs in each community with which we work. We have found that collaboration is an ongoing process, one that depends on relationships involving service providers, service recipients, and the community at large as well. We don't just ask community members to collaborate on behalf of young children and families; we get involved in a range of community issues and initiatives. New Hope Services staff have helped to found and facilitate interagency coordinating councils in Clark and Scott Counties related to teen parents, early intervention, substance abuse prevention, and family support and preservation. We also participate in communities' beautification efforts and Chamber of Commerce long-range planning, with the purpose of giving back to communities that have been so supportive.

Kids Place truly belongs to the community — 80 percent of families with young children in Scott County have accessed a program at one of our sites; all of these children have aunts, uncles, grandparents and neighbors. Moreover, our staff members are often related to service recipients and other agency staff, and to local politicians and business leaders. Our business is truly the community's business. Services are delivered in a fishbowl, and collaboration is a public process. Successes are discussed at the dinner table, and misunderstandings are a topic for conversation at halftime of the local basketball game.

Community input to program planning — often a challenge in large communities — is an informal process in Scott County, taking place at the laundromat, on the grocery checkout line, or in the doctor's waiting room. Maintaining community goodwill requires ongoing effort. Program developers and staff have to understand the informal lines of communication in order to set the record straight when misunderstandings occur. Rumors spread rapidly, so we try never to ignore the seemingly off-hand suggestion that someone's feelings may have been ruffled. Instead, we quickly seek an opportunity to drop by someone's place of business or to attend a service club meeting to ensure that misunderstandings are cleared up. The weekly community newspaper is an excellent way to communicate positive program developments, but the accidental omission of a donor's name in an article about a fundraising drive can constitute a major misstep. Again, the donor's feelings about the "snub" may only be communicated through a less-than-warm greeting at the local lunch spot; we must be sensitive enough to interpret the signal correctly and make amends.

In a multiagency setting like Kids Place, maintaining good relationships among all staff is critical. Problems arise when key players lose sight of the overall goal of serving children and families and instead promote their own particular cause or agency. Then collaborative efforts falter. In one instance, two directors of programs at Kids Place were committed to collaboration, but

front-line staff needed more preparation to work together effectively. One of the programs chose to provide services elsewhere temporarily. A consultant will work with staff of both programs to help develop collaborative programs in the future.

Mandating collaboration?

In recent years, well-meaning state and federal mandates for collaboration have presented a challenge to Scott County. Naturally occurring problem-solving collaboratives give way to required meetings with preassigned tasks. The same players gather around the table, wearing different hats depending on the current issue. Generating multiple needs assessments and action plans leaves us no time or energy for implementation. But in a small community the needs are obvious! Resources are scarce. Cooperation is a matter of good sense.

With so many new state and federal initiatives surrounding families, paperwork, rules, regulations, administrative overload, and work stress have mushroomed. Often new dollars go to satisfy administrative requirements and endless "system development." New requirements arrive weekly in a multitude of formats — requests for proposals, official policy advisories, self-assessment tools, best practice suggestions, short- and long-term action plans. Community participants and agency staff sometimes get confused at the endless meetings — are we discussing child abuse prevention, family support and preservation, teen parents, substance abuse, early intervention, or at-risk children today? Drowning in a sea of "initiatives," we have a hard time hearing the voices of county families and front-line service staff.

Lisbeth Schorr has identified several systems barriers to serving children and families well. These are: categorical funding; rigid eligibility guidelines; and deficit-oriented, rule-driven, standardized services with a narrow, categorical, and inflexible definition of professional responsibility. In small communities these barriers are particularly great. People who live in small communities don't want to be labeled, value people who (regardless of degrees or credentials)will relate to them on their own level, and resist repetitive paperwork. Income verification procedures and confidentiality issues become especially sensitive in locales where people know generations of each other's families and attend church and school functions together.

Stringent professional qualification requirements that accompany state or federal funding can actually harm programs in small towns and rural areas. The pool of people with professional credentials is small. So a program director who must employ a certified therapist, social worker, or medical professional in order to meet state or federal personnel requirements may not be able to find someone who has both the credential and the personal qualities that will allow her to thrive in a collaborative setting. If compromises are made in order to satisfy state or federal rules and the new professional does not buy into the program's collaborative philosophy, her resistance becomes an obstacle to circumvent.

The newly popular idea of independent service coordination and multiple voucher systems, which may have merit in large metropolitan areas, creates one more barrier for families in small rural communities. Inevitably, these new layers of bureaucracy also engender competition among providers that interferes with a spirit of collaboration. Child and family centers like Kids Place succeed because we are accessible, responsive, and relationship-based. Families can access a broad service system just by walking through the front door of Kids Place and talking to someone at any of the agencies located in the building. An independent service coordination system closes that door to families who have not first gone elsewhere to demonstrate their eligibility and be issued vouchers for specific services.

Treating neighbors with respect

There are many advantages to serving children and families the way we do in small communities. "Screening and assessment" can occur by stopping to chat with a mother in the waiting room at Kids Place or while dropping off a Welcome Baby Basket to new parents in the county. A "same day" home visit is not unusual. Local red tape can be cut easily. Fifteen minutes after Kids Place staff called the city-owned electric company to request the installation of a security light, a lineman was spotted on the pole outside the building. When there are health or safety concerns about children's home environments, the county sanitarian and public health nurse are just a phone call away.

So much depends on informal, personal, collaborative relationships. Kids Place and centers like it succeed because caring staff members treat their neighbors who come for services with respect. Kids Place also succeeds because of people like Pam and John Pecord, who cared enough to make a difference, and who challenged their small community to pull together for the future of its youngest citizens.

Scott County, Indiana was one of six communities studied in ZERO TO THREE/National Center for Clinical Infant Programs' five-year project, Promoting Success in Zero to Three Services, supported in part by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services. The county's experience is documented in *Living and Testing the Collaborative Process: A Case Study of Community-based Services Integration*, by Virginia A. View and Kim J. Amos, published in 1994 by ZERO TO THREE. The report is available for $14.95 plus $4 shipping and handling; to order, call 1-800-899-4301.

Delivering Prenatal and Postpartum Care in Rural New York State:

One-stop Shopping in Oneonta and Environs

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Susan is 15 years old , 16 weeks pregnant, and no longer with the biological father of the baby. She arrives at our office with her mother for her first prenatal appointment. She looks scared; her mother appears uneasy.

Michelle is 38 years old. This is her fourth pregnancy. Her children are two, six, and eight years old. Michelle is not happy about this unplanned pregnancy. She and her husband are unemployed, and Michelle says she is worried about how she will care for another child. Her husband, John, does not believe in birth control and will not permit Michelle to use any form of contraception.

Tiffany is 24 years old. Her boyfriend, Mark is 45. This is Tiffany's third pregnancy. Her two children were removed from the home because Mark was found to be abusing them and Tiffany was found to be unable to protect her children. Both children are currently in foster care.

Dana is 28 years old. She and her husband, Bill are thrilled about the prospect of having another child; they know that they want two children, and are hoping for a boy this time. Dana is an elementary school teacher; Bill is a social worker.

Susan, Michelle, Tiffany, Dana, John, Mark, and Bill represent the range of expectant parents we see in our prenatal and postpartum care practice. Their family situations and socioeconomic circumstances could be found anywhere in the country. But these families live, and our practice is located, in rural New York State.

Susan has dropped out of school, and does not want to return at this time. School personnel are supportive of this decision and not encouraging her to continue her education until after the baby is born. Susan's mother had her first child at 17, and although she says she is upset by Susan's pregnancy, she is moderately understanding. Susan is becoming increasingly isolated. She and her family live in a trailer in a secluded area. Transportation off the mountain is difficult, and school offered Susan just about her only regular opportunity to socialize with friends.

Michelle is worried about how she will find the time and money to care for a fourth child. She feels badly about being on welfare and would like to be self-sufficient. John has tried numerous times to hold down a job, but has difficulty doing so. He feels he is entitled to have as many children as he likes, even though he is unable to provide for his family without the help of welfare. John grew up in a family that survived with the

Marilyn Nolt

Note: The authors listed above are affiliated with the A.O. Fox Memorial Hospital, Oneonta, New York.

help of welfare and John sees no problem with his family doing the same. Michelle's parents worked, and were able to provide for her and her sister. Michelle does not know if she is willing to stay with John if he doesn't begin to see things her way.

Tiffany's previous relationships have all been with older men. She believes Mark cares very much for her, and is incapable of abusing her children. Mark strictly controls Tiffany's time, social activities, and finances; he knows her whereabouts 24 hours a day. The couple live in a home Mark built in the country, and have one car. Dana and Bill met at Oneonta High School, dated, attended college in Oneonta, married, and settled in Oneonta. Their supportive families live close by. Dana and Bill own a two- story home, living downstairs and renting the upstairs out.

All of these families will receive their prenatal and postpartum care at The Maternal Care Program (MCP), which serves women and their families in New York State's Otsego, Delaware, and Schoharie Counties. We four authors have each been practitioners at MCP for approximately three years. During this time we have shared with each other our ideas about how best to deliver care to our patients, and we have been able to implement many of our plans. This article reflects our experience — the challenges and opportunities we have faced, and what we have learned, individually and from each other.

The rural hospital: Geography and community

Headquarters for the Maternal Care Program (MCP) is AO Fox Memorial Hospital, a facility with 258 beds, including an attached nursing home. AO Fox is in Oneonta, New York, midway between Albany on the east and Binghamton on the west. The hospital chiefly serves patients from Otsego County, which in 1992 had a population of 61,000 (61 people per square mile), and Delaware County, with a 1992 population of 47,300 (33 people per square mile).

In rural areas, hospitals are small, few and far between. Yet rural hospitals are often a vibrant part of a small community. Because the hospital is typically a major employer in a small town, your health care providers are often your neighbors as well. In a small hospital, one department is likely to offer several services, and one staff member plays many roles. At MCP, you would find the same people offering not only prenatal and postpartum medical care but also prenatal classes, childbirth classes, a support group for parents of premature infants, Brazelton Neonatal Behavioral Assessments, an early intervention program for children 0-3 years of age, and Empty Arms Support Effort (EASE), a support group for parents who have lost a child through miscarriage, ectopic pregnancy, stillbirth, or neonatal death.

Two chief issues drive the way we provide care in MCP — the scarcity of resources in general and the scarcity of transportation in particular. Some illustrations of the challenges these scarcities present to families and to health care professionals will suggest the reasons for MCP's approach — bringing providers to patients and one-stop shopping.

Transportation

Providing prenatal and postpartum care to families in a rural setting means that you are always aware of transportation issues. Public transportation, if it exists at all, is seldom convenient for families with young children. In Oneonta, for example, buses run every hour. Even if a mother with two children has arranged her prenatal appointment around the bus schedule, if her appointment takes longer than expected, she and her children may face an hour-long wait for the bus home.

Lack of transportation also limits access to the building blocks of maternal and child health — nutritious food and contraceptive products. Most of the families we serve buy their food. Poor soil, a short growing season, and the costs of fertilizing, canning, and freezing mean that food from the market is cheaper than produce from the garden. (Cultural issues also come into play: many families do not know how to cultivate or hunt for

Diana S. Palking

food, and view any that is not frozen, canned, or otherwise pre-packaged food as a symbol of inferiority.) If a mother doesn't have a car or the time or gas money to drive to the supermarket, she may be forced to rely on a small grocery, where prices are likely to be high and the selection of nutritious food, especially fresh vegetables and fruit, low.

Rural groceries seldom carry condoms or other over-the-counter contraceptives. For patients who live 50 miles from the nearest drug store (and who are not using depo-provera or norplant for birth control), lack of transportation once again severely limits their choices.

Ironically, people in rural areas have easy access to drugs of abuse, although not to the full range used by city-dwellers. Alcohol (especially beer) and cigarettes are readily available at mom-and-pop stores. Some people do seem to know how to grow and process their own marijuana, and frequently use it along with alcohol.

Other resources

In our area of New York State, virtually all services are scarce — private and public, tangible and intangible. Problems with telephone service offer a good example of the challenges faced by families and professionals who are trying to work togethr. In an area without a trunk telephone line, families must pay a substantial deposit to the telephone company before a line is installed. Use charges can be much higher than in urban areas — a call to a prenatal care provider three miles from a family's home may be billed as a long-distance call. Families who decide to do without an in-home phone must manage with pay phones (typically found in stores or gas stations, or along the road) or depend on neighbors, friends, or family members who do have telephones to pass on messages. Using the "message phone" system to reach a patient is, obviously, full of uncertainty. While people in our community are for the most part quick to come to the aid of a neighbor, passing along messages regularly can be time-consuming, expensive, and irritating.

As service providers in a rural area, we face limitations in both the range of resources we can offer to patients and the availability of services that do exist. The public health nursing service is frequently understaffed, with one nurse covering a great deal of territory. The small number of shelters for battered women are usually full. Few beds are available in psychiatric hospitals, and at the local mental health clinic, appointments must be made weeks in advance. Because many county offices close at 4 p.m., a nurse or social worker who sees families all day can't use the late afternoon for care coordination — at least officially. (What happens, in fact, is that professionals link services for their patients after hours. We know the key people in each agency — indeed, the DSS caseworker, the public health nurse, or the psychologist at the mental health clinic is likely to be our neighbor. Professionals have both telephones and a sense of community. So we call each other in the evening to pool our resources on behalf of families.)

Models of resourcefulness: Outreach and one-stop shopping

The resourcefulness, creativity, and flexibility that providers must use to serve families well in rural areas helped MCP devise its current approach to overcoming transportation barriers to care. Our first step was to categorize our patient population by zip code. When we identified a group of families in a given geographical area outside the city of Oneonta, we investigated the possibility of establishing an outreach site there. Our investigation would include a needs assessment and discussion involving community leaders and existing

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ZERO TO THREE

NOVEMBER 30 - DECEMBER 3, 1995
Atlanta Hilton Hotel and Towers
Atlanta, Georgia

Tenth National Training Institute

Join us in Atlanta for a lively and diverse Institute featuring internationally acclaimed leaders in the infant/family field.

The Institute is a unique opportunity to come together with colleagues from all disciplines to explore timely issues and to learn about best practice in the rapidly growing infant/family field.

Opening Remarks by Former First Lady Rosalynn Carter (Friday)

Pre-institute Sessions

All day Thursday - Friday morning

- A full-day forum on the evaluation and treatment of infants and toddlers exposed to violence
- Two half-day workshops on infant mental health and supervision and mentorship
- Eleven seminars on such cutting-edge issues as maternal substance abuse; new visions for pediatric primary care; autism and multisystem developmental delay; new developments in the NICU; diagnostic classification - the relationship axis; sensory processing dysfunction; and funding your programs.

Institute Sessions

Friday afternoon - Sunday noon

- Three plenaries on the current status of the infant/family field; infants and toddlers in the foster care system; and the latest research on early memory
- Twenty-three peer-reviewed seminars
- Peer-reviewed poster session
- Video theatre
- Exposition

Program Highlights

FULL-DAY FORUM (Thursday)

Evaluation and treatment of infants and toddlers exposed to violence

Betsy McAlister Groves, LICSW, Marva Lewis, Ph.D., Joy D. Osofsky, Ph.D., and Charles H. Zeanah, M.D.

HALF-DAY WORKSHOPS (Thursday)

Integrating an infant mental health perspective into early intervention

Barbara Ivins, Ph.D., and Donna Weston, Ph.D.

Establishing and protecting supervision and mentorship in infant/family programs

Brenda Dobbins-Noel, M.Ed., Maureen Moreland, M.A. and Rebecca Shahmoon Shanok, M.S.W., Ph.D.

PLENARY SESSIONS
(Friday - Sunday)

Supporting the development of infants, toddlers, and their families: A look at the past, a vision for the future

Jeree H. Pawl, Ph.D., and Jack P. Shonkoff, M.D.

Searching for the best interests of the child: Protecting infants and toddlers in the foster care system

Alicia F. Lieberman, Ph.D., and Jacqueline Payne, Esq.

The development of memory in the earliest years

Stephen J. Ceci, Ph.D., Judy Deloache, Ph.D., Katherine Nelson, Ph.D., and Arnold J. Sameroff, Ph.D.

Institute Schedule at a Glance

Pre-institute					
Thursday, November 30	**10 am–4:30 pm** Full-day forum on Treating Children Exposed to Violence	**9 am–12 noon** Half-day workshop on Infant Mental Health	**1–4 pm** Half-day workshop on Supervision and Mentorship		
		The Institute			
Friday, December 1	**9–11:30 am** 11 pre-institute seminars	**1–3 pm** Opening plenary on Current Status of Field	**3:30–5 pm** 10 special interest sessions	**5:30–7 pm** Reception/meet the authors of ZERO TO THREE publications	
Saturday, December 2	**8:30–10:30 am** Plenary on Foster Care System	**11 am–12:30 pm** 10 special interest sessions	**12:30–2 pm** Luncheon, with featured speaker, *T. Berry Brazelton*	**2–3:30 pm** Poster session with exhibits	**3:30–5 pm** 10 special interest sessions
Sunday, December 3	**10 am–12 noon** Final plenary on Early Memory Research				

Pre-institute seminars

Friday morning

The social and emotional development of infants and toddlers affected by maternal substance abuse
Josephine V. Brown, Ph.D. and Claire D. Coles, Ph.D.

Using video to identify family strengths
Victor J. Bernstein, Ph.D. and Susan McDonough, Ph.D.

New opportunities in pediatric primary care: Moving beyond traditional boundaries
Kathryn E. Barnard, R.N., Ph.D., T. Berry Brazelton, M.D., Margot Kaplan-Sanoff, Ed.D., Ann Stadtler, MSN, CPNP, and Barry Zuckerman, M.D., F.A.A.P.

Serving young children with HIV infection and their families in community-based settings
Geneva Woodruff, Ph.D.

The Relationship Axis of ZERO TO THREE's Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3): Implications for assessment and intervention
Roseanne Clark, Ph.D. and Robert J. Harmon, M.D.

Intervention for young children with sensory processing dysfunction
Marie E. Anzalone, Ph.D., OTR, and G. Gordon Williamson, Ph.D., OTR

Infants, families, and professionals in the neonatal intensive care unit (NICU): Building mutual trust
Heidelise Als, Ph.D., Linda Gilkerson, Ph.D., and Helen Harrison

Visiting three cultures through child play, festivals and stories
Pat Franco, M.A., Maria Elena Orrego, M.A., and Marilyn M. Segal, Ph.D.

Securing your program's future in an uncertain funding climate: Tips from public and private funders
Haida S. McGovern and panel

Training early intervention practitioners in rural settings
Sue Forest, Ph.D. and Kathleen Gallacher, M.A.

Creating family sensitive, comprehensive treatments: Interactive relationship-based intervention approaches for children with MSDD (multisystem developmental disorder)
Barbara Kalmanson, Ph.D. and Serena Wieder, Ph.D.

Windows on work in progress

Special invited presentations (Friday - Saturday)

Knowledge is power: Collaborating to enhance the benefit of research for the people who "are studied"
Efrain De Jesus,M.A. M.S.W. and Ann P. Turnbull, Ph.D.

Applying family support principles to professional education: Linking universities, community programs, and state agencies
Dolores G. Norton, Ph.D. and Bernice Weissbourd, M.A.

How can what we know about early emotional and character development be used in parenting interventions? Partners in Parenting Education (PIPE): A new program
Perry Butterfield, M.S. and Robert N. Emde, M.D.

Framing advocacy from a new perspective: Making the case without conclusive data
Samuel J. Meisels, Ed.D. and Matthew E. Melmed, J.D.

Developmentally appropriate group care for infants and toddlers
J. Ronald Lally, Ed.D.

Integrating a therapeutic play group into child care settings for children 3-6 years of age
Kadija Johnston, L.C.S.W. and Rebecca Shahmoon Shanok, M.S.W., Ph.D.

Varying perspectives on very young children with autism
Lauren B. Adamson, Ph.D., Barbara Dunbar, Ph.D., and Gail G. McGee, Ph.D.

Presentations from the field/special activities

Peer-reviewed presentations
(Friday - Saturday)

Twenty three (23) symposia and case presentations from the field will be presented at three special interest sessions, Friday afternoon, Saturday morning and Saturday afternoon. Over **100 posters** will be presented on Saturday afternoon as well. Presenters will share their research findings, describe service delivery models, offer approaches to parent and professional training, demonstrate approaches to screening, assessment and evaluation, and report on public education initiatives.

Video theater (Friday - Saturday)

A broad selection of classic and new videos in the infant/family field will be shown at convenient times during the Institute.

Exposition (Friday - Sunday)

The Exposition will provide access to publishers of books and periodicals in the infant/family field; recruiters for professional staff; manufacturers and distributors of furniture, equipment and toys for child care and early intervention settings and computer hardware/software used in the management of infant/family programs.

Networking/social activities

The Institute will offer numerous opportunities for veteran participants as well as newcomers to the Institute to get acquainted with others and enjoy informal interaction. There will be a reception on Friday evening where you will have time to talk with colleagues, including authors of ZERO TO THREE publications and Institute presenters.

Thursday and Saturday evenings, there will be a place to meet other participants interested in joining you for dinner or an evening out.

Exhibits will be open for major portions of the Institute, so that you can browse at your convenience.

Atlanta

Atlanta has many fine attractions which include several fine arts museums, botanical gardens, The Martin Luther King, Jr. Center for Non-Violent Social Change, The Jimmy Carter Library and Museum, the Atlanta Zoo, Underground Atlanta, which offers specialty shops and entertainment, and Peachtree Center, which features restaurants and shops. Specific information on the city, its restaurants and attractions will be available at the Institute.

Hilton Hotel

The Atlanta Hilton Hotel and Towers is located in downtown Atlanta within walking distance of the center of the city and a subway ride from the airport.

Registration

Complete Institute costs, as well as hotel and registration materials, will appear in the Institute program to be mailed in June to all *Zero to Three* subscribers.

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Kathryn Barnard, R.N., Ph.D., University of Washington
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Josephine Brown, Ph.D., Georgia State University, Atlanta
Perry Butterfield, M.S., University of Colorado School of Medicine, Denver
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service agencies. Each of the four outreach sites in Delaware and Otsego Counties offers not only prenatal and postpartum care but also the full range of other services available at the home office — prenatal and childbirth classes, EASE, Brazelton assessments, and early intervention. The only services that we cannot offer at our outreach sites are ultrasound and nutrition counseling by a registered dietician.

Of course, patients still have to travel to outreach sites, but reducing the distance they need to travel for care makes a great difference. With the MCP office close by, asking a friend for a ride is not a great imposition; using the family's one car for an appointment doesn't tie it up for too long.

One-stop shopping makes service delivery at outreach sites even more efficient for families and staff. With this approach, all a patient's appointments are scheduled for the same day at the same facility — i.e., prenatal medical care appointment, consultation with the social worker, etc. (The postpartum visit involves a physical assessment by the nurse-midwife, a discussion of birth control, and, if appropriate, an initial injection of depo-provera.) An initial appointment can last two to three hours. Although this approach offers high-quality, comprehensive, and integrated care, the day can be very long for the patient, her family, and the care provider. We encourage women to bring their children with them: we have books, toys, and a television with VCR, and staff view child care as one of their responsibilities. Because an initial appointment can stretch over a meal time, we also provide nutritious snacks for families.

Offering one-stop shopping at an outreach site works only if appointments are kept. Having a nurse and midwife travel 45 minutes each way to and from an outreach site to see three patients is worthwhile; but if only one of the three patients keeps her appointment, the approach is no longer cost-effective. In order to reduce potential reasons for cancellations, we make great efforts to schedule appointments at the convenience of the patient, rather than the provider. Thus our patient Michelle might want a late-morning appointment so that she could see her six- and eight-year-old children off to school before coming to the office. Dana, a school teacher, might find a late afternoon or evening appointment easier to keep. Flexibility is an important component of providing care at our outreach sites.

Given our limited resources and the wide range of families we serve, we have to make choices about where to invest our time. Nurses, midwives, physicians, and the MCP social worker spend an enormous amount of time educating our patients about the hazards of drug use during pregnancy — through prenatal and childbirth classes and on an individual basis throughout prenatal and postpartum care. If we think that a mother is using alcohol or other drugs (we estimate that 10-20 percent of our patients are using alcohol or drugs during pregnancy) and this is confirmed by a random drug screening (performed with patient consent at the initial visit), we do a Brazelton assessment with the baby and family as soon as possible after birth in order to help the mother recognize the baby's characteristic responses to stimuli and suggest techniques for soothing the baby and encouraging positive interactions. With parental consent, we can refer an apparently healthy baby to the state Infant/Child Health Assessment Program (ICHAP) for monitoring or a baby who is showing delays to the local Early Intervention Program, which can coordinate services for children with developmental delays. We would like to be able to offer all our patients Brazelton assessments, but due to limited space and time, we can now offer it only to high-risk families.

The camaraderie of community

Belonging to a professional community in a rural area offers many rewards. Out of necessity, one professional develops many areas of expertise. This allows families continuity of care with one provider instead of a series of referrals to different professionals. It allows professionals to get to know patients and their families well enough to develop some insight into their lives.

In our rural area, families have a sense of community, a feeling of home. Professionals have an appreciation for each other's work and a deep sense of camaraderie. With limited resources available to us and the families we serve, we use creativity and flexibility to shape prenatal and postpartum care. For today, the plans we have devised are working well. For tomorrow, we might have to modify things just a little bit.

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Elk in the Road, Chicks in the Foyer:

Infant/family work in rural areas

Shelley Marie Windsor, M.A., CCC-SLP Lander Valley Medical Center, Lander, Wyoming

In October, 1994, I wrote to ZERO TO THREE about the problems I was seeing in rural areas — an overall lack of service providers trained to work with infants, toddlers, and their families; isolation among the providers who do exist; and few resources for training people in early intervention. I had heard about ZERO TO THREE's 1992-93 City TOTS (Training of Teams) project, which helped teams from large cities improve training for infant/family workers, and I hoped that ZERO TO THREE could develop and implement a TOTS program for rural service providers. Instead, the editor of *Zero to Three* asked me to write about my experiences as a rural provider of services to young children and their families.*

Since I graduated from California State University at Chico in 1986 with a master's degree in speech/language pathology, I have worked with young children and families in rural communities all over the country, in center-based, home-based, and combined early intervention programs. My first job as a speech-language pathologist was on the Blackfeet Indian Reservation, in Browning, Montana. When the state's public schools began to serve three- and four-year-olds, I moved to Kalispell, Montana and implemented a center-based preschool program for children with language delays. It was my first attempt at working with very young children, and I loved it. When I moved to Angel Fire, New Mexico in 1989 to work as a speech-language pathologist with pre-schoolers in a rural educational cooperative, the director of an early intervention program asked me to work one day a week with infants and toddlers. I jumped at the chance. In 1990, I left the public school system altogether and started working full-time with children from birth to five years of age at several early intervention programs in communities within a 200-mile radius of my home. In 1994, I moved across the country to New Hampshire and began working with a home-based early intervention program in Littleton, in the White Mountains. Now I am in Lander, Wyoming, working at the Lander Valley Medical Center as a speech-language pathologist. I am working on developing an infant massage program at the Medical Center (I am already giving presentations to prospective parents about infant massage in prenatal classes), thinking about putting together a team to do more in-depth evaluations and assessments, and making contact with early intervention and three- and four-year-old programs in Dubois, a community an hour and a half's drive away from Lander.

I like living and working in rural areas because of the sense of freedom and the sense of community I feel in the country. Big open spaces, learning about new cultures, and meeting kindred spirits all appeal to me. The demands of daily life in rural areas can be harsh, however. Resourcefulness, flexibility, and teamwork are essential — for families and early interventionists alike.

Travel

Driving is part of the job for an early interventionist in a rural area. Service providers know it, and families know it. While I imagine that most early interventionists in home-based programs travel a great deal, a rural early interventionist may drive hundreds of miles in a day, through all types of weather.

For me, the travel involved in my job is a pleasure, not a burden. I feel fortunate to have a chance to drive to work through beautiful country, seeing the natural world instead of a crowded freeway or a city traffic jam. Driving is a great time to dictate home visit notes, practice stress reduction techniques, plan, and sing.

It's important to keep alert while driving. I haven't tried the buzzer that fits over your ear and sounds off if your head falls to the side, but the idea sounds good. Just about the worst thing that can happen to a country driver is hitting an animal in the road. Hitting a bear, deer, elk, or moose not only kills or maims the animal, but can totally wreck a car. Late one night, a large bull elk stepped in front of my headlights. He was huge — and so close I could see the terror in his eyes. Fortunately, I was driving slowly enough to be able to swerve and miss him. I'm thinking about buying a whistle for the front of my car that will let animals know I'm coming.

Editor's note: Sorry about that. Actually, even while the City TOTS project was going on, ZERO TO THREE staff and Board were wondering what it would be like to develop a Country TOTS project. However, at the time Shelley Marie called, resources for such an initiative were not available. Consequently, we encouraged her to join in a process that is often effective in improving services for young children and families — document a need, create awareness of opportunities to make positive change, find partners and resources, implement a vision, and share what has been learned. Thank you, Shelley Marie, for taking some important first steps.

Even without encounters with large animals, getting to and from a family's home can be quite an adventure. One family I worked with lived only 30 miles from town, but the "short cut" involved driving down into a canyon on a single-lane dirt road with no guard rail, crossing a bridge, climbing back up the canyon on another dirt road, and then driving out over the mesa. When the short-cut was impassable, the alternate route added half an hour to the trip. Although there was a community bulletin board at the beginning of the second dirt road (I soon learned to stop there and look for messages from the family), the first time I tried to visit, I drove around for 20 minutes looking for their home until another driver came along and pointed me in the right direction. (Fortunately, in rural areas everyone usually knows everyone else).

Everyone talks about the weather in rural areas, and the conversation is serious. You learn quickly to listen (and pay attention) to weather reports and to consult with families about the weather. Early in my career, I risked being "weathered in" more than once. My most frightening experience occurred on one of my monthly visits to a small village near the Colorado/New Mexico border. When I left home early in the morning, a "snow advisory" was in effect, but the road seemed good, so I continued. During the visit, snow began falling harder. The family suggested that I start back immediately and take the longer route instead of the short cut. I left, but because the short-cut road was still open I took it. Using the short cut, I reasoned, I would be home in an hour and a half; the long route would take me three hours.

As I started on the short cut, it was snowing pretty hard, and the situation got worse by the minute. When I reached the top of the pass, my car started to slide, so I down-shifted and drove the rest of the way in first gear. I started making survival plans and taking a mental inventory of the emergency equipment in my car (see New Mexico's Step-Hi program's suggested list of emergency equipment, p. 20). Each time I passed a summer ranching shed, I envisioned myself struggling to reach it and then being stranded for days waiting for a snow plow that might or might not arrive. I did get home safely — five hours after leaving the family. I have learned the importance of having a reliable car, of keeping my "emergency box" well stocked, and of appreciating families' concern for my safety.

Travel tips for home visiting

Carry maps of the state, county, and city you are traveling in. Clearly mark the best and alternate routes on each map. Write addresses and phone numbers of family homes on the map. More detailed direction to each home can be written on post-it notes and mounted on the map.
Insert each map in a clear plastic folder and fasten it to a clipboard.

Independence, resourcefulness, and flexibility

Families who tell me, "Don't come if the weather's bad," seem to be taking responsibility for where they live, as well as showing concern for me. In my experience, rural people are very proud of their independence. Understanding the advantages and disadvantages of choosing to live outside the mainstream, they are comfortable with their choice. They are proud of their ability to survive and flourish with the seasons.

One of my best memories is of working with a family who lived on a farm in New Hampshire. I visited them for the first time in the fall. The weather had turned cold, so the P's had brought some newly hatched chicks into the foyer of the house to keep warm — a somewhat surprising sight for me, but a routine measure to save chicks from the cold. My own work with the P family was a bit unconventional, as well. Mickey, age two and a half, had been diagnosed with impaired vision and pervasive developmental disorder. Mrs. P., undaunted by the diagnosis, spent her time with Mickey going for walks in the woods to gather mushrooms and simply explore. When I visited, we walked through the garden in warm weather or went out to the barn to see the animals. I didn't follow the standard treatment protocol of teaching Mickey to name the parts of his body; he was more interested in learning the parts of a tractor, and that's what we worked on.

My work with Daniel and his family was even less conventional. Daniel came to our early intervention program when he was three years old, shortly after his family had returned to the United States from abroad. Daniel weighed 20 pounds and had an unrepaired cleft of the soft palate, a partial cleft of the hard palate, cataracts in both eyes, and other anomalies. He ate only spiralina (a seaweed derivative sold in health food stores), which he sucked from a bottle with a very large hole in the nipple. Daniel's mother, Mrs. R., did not see

how early intervention could help her son, but was willing to drive him to the center — a distance of 30 miles if the short cut was open. During the two years Daniel was with the program, he made many gains. He ate pureed foods from a spoon and became mobile by scooting on his back, using his foot, and rolling. Daniel held his favorite toys and other objects close to his face so that he could see them (Mrs. R. refused invasive procedures, such as cataract surgery). Many individuals and agencies became involved in Daniel's care, including the New Mexico Preschool for the Visually Handicapped, which provided a light box, a device used to stimulate Daniel's limited vision. Mrs. R. also took Daniel to a Native American sweat lodge. She told me about her significantly spiritual experience there and said that the medicine man told her that soon Daniel would be well and living happily. Six months later, Daniel died. Even after his death, Mrs. R. continued to call and stop by our program office. I believe that for Mrs. R. our program was a trustworthy link to the "conventional" world. We respected her beliefs and did not ridicule her efforts to help Daniel. (This level of personal trust develops slowly between families and early intervention staff and must be nurtured carefully. Not surprisingly, some families have difficulty making the transition from early intervention programs to public school settings with fewer resources and options.)

Early intervention as human connection

Especially in isolated rural areas, the relationship between an early intervention provider and a family offers many kinds of human connection. A weekly home visit becomes important not only for the "intervention" but also for socialization. Part of preparing for a home visit may be calling ahead to see if you should stop to pick up diapers or groceries on your way. The visit becomes a time for families to hear news of what is going on in town and road conditions.

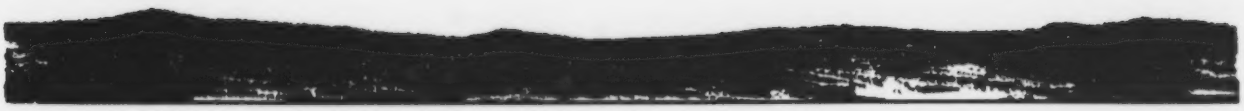
Families need to talk about what is going on in their lives. Mr. and Mrs. D. lived with their three small children in a trailer, 10 miles from a small town. Mr. D.'s SSI benefits were the only source of income; the D.'s had no car. Mrs. D. told me about her dreams of completing high school and finding a job. I helped her manage the transition of her three-year-old into a public school program and also with locating transportation and child care. Mrs. D. found a job at a flower shop where she could bring her six-month-old daughter along, and started working toward her GED.

The S family lived on an isolated ranch. Mrs. S. worked at an area ski resort; the wife of the resort manager was a speech-language pathologist and knew me. These connections made Mrs. S. feel comfortable about calling our early intervention program to express general concerns about the development of her two-year-old son. Although Mrs. S. sometimes talked about her children during home visits, she began to focus more on Mr. S.'s drinking and abuse. Ultimately, Mrs. S. decided to leave her husband and returned to school.

In rural areas, change may come slowly. Kate was diagnosed with microencephaly at birth, and later with cerebral palsy and mental retardation. She was referred immediately to early intervention, and a nurse/developmental interventionist provided care at home and talked with Kate's parents, Mr. and Mrs. L. It took six months before Mr. and Mrs. L. felt strong enough to have a physical therapist evaluate Kate; it took another year for them to call on my services as a speech-language pathologist. From then on, however, every day for six years the L's found a way, with support from us, to get Kate to the center-based early intervention pro-

The Rural Early Interventionist's Emergency Box

Road emergency kit: Flares, jumper cables, flashlight, CB radio powered by cigarette lighter or cellular phone with extra batteries, fuses
Air pump powered by car's cigarette lighter
Flat tire repair kit
Hammer and screwdriver to remove hubcap
Shovel with folding handle
Traction treads (slim-line traction treads, snow claws)
Bag of kitty litter for traction
Can of salt to melt snow and ice
Can of kitchen matches for frozen locks, and to start fires
Snow brush/ice scraper
First aid kit
Space blanket/sleeping bag
Heavy waterproof boots; hat
Heavy waterproof gloves/mittens
Sweatsuit and comfortable shoes; change of clothing
Toothbrush, toiletries, necessary medications
Handiwipes
Paper/thick red crayon for writing message on car window
Distilled water (one gallon)
High-energy snacks



gram, 60 miles from their home. When it was time for Kate to move into the public school at age 7, the L's couldn't understand why Kate couldn't stay in early intervention. Careful coordination with the public school program eased the transition. The physical therapist and I were able to continue weekly home visits under the auspices of the New Mexico Developmental Disabilities Program. I also worked with Kate in her school classroom and helped her establish a relationship with her new speech-language pathologist. Despite the extra travel involved, it was exciting to see Kate learn about her environment and meet its challenges.

These stories illustrate the diversity and complexity of relationships. Services to families need to be truly individualized. I have noticed a current trend in rural communities for programs with limited resources to ration services across the board — every family gets a monthly visit from an interventionist, and professionals with special qualifications are relegated to consulting roles. Moreover, this approach is justified as "transdisciplinary best practice." When this policy was begun in a program where I was working, I felt that working this way would compromise my professional ethics, and soon left the program.

Training for teamwork

Few people trained in early intervention work in remote areas. Service providers in rural areas are frequently paraprofessionals. Therapists with a professional degree in one discipline may be assigned multiple responsibilities — even though they have not had the time or opportunity to develop transdisciplinary skills. The challenge for the field, as I see it, is to find ways to connect rural providers with sources of information, consultation, supervision, and further training. Everyone benefits when interventionists expand their body of knowledge and develop confidence and pride in their skills.

I have worked closely with paraprofessionals and have become more and more involved in their training. Paraprofessionals live in a community, are committed to it, and are trusted by families; they can draw a professional into the community. In New Mexico, the state department of health, Project DREAM, and Specialized Therapies project have a joint scope of work to develop recommended practices regarding the use of consultation and paraprofessionals. More resources are needed to train the trainers of paraprofessionals.

As a rural early interventionist, I have to fight constantly to avoid professional isolation. Getting to know staff at the child development centers that do outreach or provide comprehensive evaluations and diagnosis for children referred from rural areas is a way to build my own relationships with colleagues from other disciplines and to offer a more integrated service to families. For example, the New Mexico Preschool and Infant Evaluation (PIE) program sends a team with a physician, educational diagnostician, physical or occupational therapist, and speech-language pathologist to do evaluations in rural areas. Even with this outreach, however, families typically have to travel many miles to the evaluation site. By getting to know the team, I could talk to families about what to expect from the evaluation and help build trust in the procedure. I could contribute my own understanding of the child and family, confirm concerns, and discuss what I should look for and approaches I could try in my own assessment and intervention work. It is valuable and reassuring to know that I can call someone if I am stumped about a child and/or family. It helps me to grow, and to know that I am not out there alone. To me, knowing when to ask for help is a sign of professional maturity.

I talk to as many other interventionists as possible, anywhere I can and any way I can. I have consulted with others through phone calls, meetings, and videotapes. Mentorship programs are important to help young therapists grow and become confident, especially in remote areas where one can feel alone and struggling.

I have been fortunate to have supervisors and program directors who supported my efforts to get further training. While working in New Mexico, I received a stipend to participate in training in early childhood speech-language assessment and treatment and in family systems at the University of New Mexico. This involved driving 300 miles round trip once a week for two semesters. Luckily, I could arrange my schedule to combine travel, home visits and classes into one two-day trip each week. My supervisors valued the training and worked around this schedule. This experience led to Nursing Child Assessment Satellite Training (NCAST) and training in infant massage. Maria Mathias, the instructor, not only shared her joy in infant massage but also helped early interventionists from all over New Mexico feel more comfortable with each other and learn how to take care of ourselves, as well as families.

In Littleton, New Hampshire, colleagues encouraged me to go through the eight-week basic Neurological Developmental Treatment (NDT) course. This involved

traveling 2,000 miles and leaving an established practice and friends behind. The Littleton Early Intervention Program made it possible for me to move, participate in training for two months, and have my job waiting for me. The arrangement was beneficial to everyone: the agency gained integrity through having better qualified staff; families were better served; and I grew professionally.

Individuals grow through training, and so do teams. The teams I have worked with that have really clicked all had to go through a process of "creative conflict" in order to grow stronger. The Los Angelitos early intervention program in Taos, New Mexico brought in trained facilitators to help team members resolve conflicts. Four days of joy, pain, tears, and revelation brought the team closer together and helped us develop a level of trust with each other that I have never experienced since. Our field needs more administrators who see the value of recognizing and working through conflicts.

Challenges for the field

To advance the field of early intervention in rural areas, we need more training, support, and development opportunities. I would like to see support for a Country TOTS (Training of Teams) project and for more initiatives like Zia Special Therapy Projects. These are needed to connect rural providers with sources of current information in the field. Systematic exchange of videotapes or teleconferences could supplement face-to-face training.Support networking and peer consultation efforts among rural providers (with course credit or CEUs for members attending) would draw new practitioners into the field. I am sure efforts like this are going on somewhere — but how will I (and my country colleagues) find out about them and gain access to them?

Families and early interventionists in rural America will continue to use resourcefulness, flexibility, and teamwork to do the best we can for infants and toddlers with special needs. We need partners and resources to fulfill our vision.

Rural Early Intervention Training:

Challenges and Strategies

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Providing services, resources, and support to infants and toddlers with disabilities and their families in remote rural communities requires all the knowledge and skill needed to work effectively with young children and families anywhere — and much more. Designers and administrators of rural early intervention efforts and the institutions that train rural early interventionists must take into account: 1) a population that is spread sparsely across a large land area; 2) specific (and often diverse) geographic and climatic features of the area to be served; 3) low base rates of disability; 4) difficulties in recruiting and retaining qualified personnel; 5) unequal distribution of available service providers; 6) scarcity of public transportation; and 7) values and rules of rural culture as they relate to individuals with disabilities and to early intervention.

An early interventionist in a rural state like Montana (the fourth largest in area, with only 800,000 people) may travel 1500-2000 miles each month in order to visit families every two weeks. In between visits, the interventionist uses telephone calls, exchange of video and audiotapes, and collaboration with family members and community paraprofessionals to carry out the service plan. She must be able to reach families that do not have television or radio, search a computer network for information about a rare syndrome, drive defensively in difficult terrain, and respect families' concerns about using "outside help."

To prepare early interventionists for such diverse demands, the Rural Early Intervention Training Program (REIT) at the Montana University Affiliated Rural Institute on Disabilities has developed, implemented, and evaluated a set of early intervention competencies for rural environments, and has devised special instructional strategies and techniques. REIT's design also addresses a range of personnel recruitment and retention issues specific to rural areas. These include: social and cultural isolation, leading to high turnover among professionals; a high proportion of young and inexperienced staff members; and the tendency to hire local residents with limited qualifications, to be trained on the job.

Robert Maust /Photo Agora

Early intervention competencies for rural environments

Wherever they practice, early interventionists need to acquire and demonstrate competence in work with infants and toddlers, work with families, child assessment, gathering information with families, program planning, community service delivery, implementation and program evaluation, and professional development. REIT has identified a set of specifically rural early intervention competencies related to these more general competencies. These form the foundation for the program's lectures, assignments, applied practical experiences, and practicum experiences.

Competencies necessary for working with infants and toddlers in rural environments:

The rural early interventionist must have knowledge of disability and health problem prevalence in rural areas. Low base rates of disability, due to the sparse population, mean that service providers must often be generalists, serving individuals from birth through old age who may be "at risk" or may have severe disabilities. The rural early interventionist must know how to get more information herself and how to help families use various media (for example, mail, E-mail, FAX, telephone, and phone conferencing) for information and connection to families with similar disabilities. The rural early interventionist should also be aware of the potential impact on early development of the rural physical environment and of rural cultural and sociological factors.

Competencies necessary for working with families in rural environments:

The rural early interventionist must be knowledgeable about family support systems in rural regions and about rural child-rearing practices. She must recognize that rural culture tends to see value as lying within the individual rather than with the power, skills, or knowledge that the individual has acquired. Consequently, rural families may de-emphasize and tolerate individual differences in behavior and development more readily than families in other environments. The interventionist must recognize that each family has its unique place along a continuum of ethnic and cultural diversity; there may be subtle differences, for example, between the attitudes of families who have homesteaded in rural Montana for generations and families who have recently migrated to Montana in order to get away from other people and take care of themselves. The rural

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early interventionist must understand the seasons and rhythms of planting, harvesting, calving, and butchering, as well as the cultural roles of farm equipment dealers and grocers, churches and grange halls, bookmobiles and public schools. She must be aware of families' core values (for example, independence, work, spirituality) and patterns of daily living (for example, problem solving, shopping, recreation).

Competencies related to child assessment in rural environments:

The rural early interventionist must be able to design an appropriate and feasible assessment process that will take into account families' routines, transportation issues, and the availability of assessors with appropriate expertise. She must be aware of cultural, social, and ethnic influences on the assessment process, including the meaning of young children's play in the rural context.

Competencies related to family information-gathering in rural environments:

The rural early interventionist must know how to develop a relationship with families as a foundation and context for information gathering, as well as about effective strategies for information gathering by phone or mail if necessary. Working with families to identify resources to help support their goals requires a knowledge of both formal and informal options. For example, when the family identifies a need for transportation to services, the interventionist should be aware of the range of publicly funded options (senior citizen vans, Head Start or public school buses) that might be used and should also be able to think with the family about formally bartering resources with a neighbor (Mr. Jones will fix Mr. Johnson's tractor in exchange for Mr. Johnson's driving Mrs. Jones and their young son to the early intervention program in town.)

Competencies related to program planning in rural environments:

The rural early interventionist must be able to use a variety of strategies for developing the Individualized Family Service Plan (IFSP) with families and professionals in rural contexts. She needs to be familiar with and able to use (independently, or with support) a range of electronic and audiovisual technology in order to link professionals and families. She must appreciate the impact of rural culture, keeping in mind that families that place a premium on taking care of themselves may be best served by a menu of options, including: child/family-focused intervention; parent skills training; support coordination; and/or resource coordination.

In designing child-focused and family-focused outcome statements, the rural early interventionist must be flexible in accommodating demanding and season-specific job responsibilities that may limit rural families' involvement in early intervention activities (e.g., Child Find) and services (center-based programs). The scarcity of professionals in remote rural areas demands that early interventionists be able to work with and train other professionals (who may be visiting other families in a specific locale) and paraprofessionals (who may live relatively close to a target family) to develop, implement, and evaluate IFSP's and transitions in collaboration with families.

Competencies related to community service delivery in rural environments:

The rural early interventionist must be knowledgeable about: service delivery approaches in small towns and rural communities; staffing patterns, team models, and team dynamics; and strategies for coordinating support and implementing programs. Problems associated with recruiting and retaining personnel mean that the composition of teams in remote rural areas will be more dynamic and transient than elsewhere. The rural early interventionist must be skilled in linking professionals with each other and with families and in using transdisciplinary approaches to train and support professionals and paraprofessionals.

Competencies related to implementation and program evaluation in rural environments:

The rural early interventionist needs to be able to develop comprehensive programs, addressing all developmental domains, while keeping in mind the rural context of service delivery and the cultural and socioeconomic factors that will influence program implementation. She must use a variety of strategies and resources to implement, monitor, and evaluate intervention and transitions, and be able to collaborate with parents, other relatives, paraprofessionals, and other professional service providers.

For example, an early interventionist who is able to visit a family in a remote area only every other week must be able to develop a variety of options for alternate weeks, from which the family can choose. One option might be visits by a paraprofessional (keeping in mind that the paraprofessional could be a family member, relative, friend) who is trained or supervised by the early interventionist and who is responsible for implementing the objectives and activities of the IFSP with the child and the family between visits. The training may occur directly, when the early interventionist is visiting the family, or by videotapes made as the early interventionist, another therapist, or a family member works with the child and provides instruction and activities for the paraprofessional to implement. Ultimately, the early interventionist, in collaboration with the family, will monitor the work by the paraprofessional either by reviewing videotapes taken of the sessions or by either written or oral feedback provided by the family and/or paraprofessional. A second option might involve the

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early interventionist and family collaboratively developing a set of activities that the family will implement between visits. Again, this can be accomplished by direct observation of the early interventionist or therapist modeling specific intervention techniques and/or through the preparation of an audio or video tape describing or demonstrating what should be done. A third option could be an every-other-week phone conference with the family during which the early interventionist asks how things are going in general and checks to see if the family has any questions, concerns, or feedback regarding the implementation of activities they have planned together.

Competencies related to professional development in rural environments:

The early interventionist working in remote areas, far from program supports, needs to develop practical skills that may be required to ensure her own, children's, or families' survival — defensive driving, emergency first aid and CPR, and the ability to recognize and prevent potentially dangerous situations. Professional development involves the ability to work collaboratively with professionals and others in rural communities, and in a supervisory relationship to paraprofessionals and volunteers. To grow professionally, the rural early interventionist must also be able to use resources at a distance — people, libraries, and other sources of scientific and practice research.

Rural Early Intervention Training strategies and techniques

The Rural Early Intervention Training program is committed to providing preservice students opportunities to acquire both general early intervention competencies and competencies specifically related to early intervention in rural areas (Mills, Vadasy, & Fewell, 1987). At REIT, specific rural competencies cut across and are linked to six core early intervention courses plus an intensive practicum experience. Graduate and upper-level undergraduate students in health, education, and human services programs are eligible to take the courses, which are offered both on- and off-campus.

The Rural Early Intervention Training program emphasizes instructional strategies and techniques that enable early interventionists not only to gain knowledge but also to practice skills that will enable them to be effective with families and other professionals. These strategies and techniques include: 1) competency-based training; 2) self-directed adult learning; 3) a problem-solving orientation; and 4) cooperative learning.

Competency-based training:

The early intervention competencies for rural environments described above form the foundation for REIT's lectures, assignments, applied practical experiences, and practicum experiences. Students are required to provide 160 hours of respite care services to families who have children with disabilities. They must provide the care to a minimum of two families over a two-year period. This aspect of the program is designed to provide the student the opportunity to see child and family change over time and to develop competence in communicating and interacting with family members. Furthermore, each of the courses requires the students to practice the skills and techniques they learn in a center-based setting that includes infants and toddlers with and without disabilities and their primary caregivers. All quizzes, exams, and assignments are applied, requiring students to integrate and synthesize readings and lectures to help them solve problems and dilemmas that they will encounter when they are practicing early interventionists.

Self-directed adult learning:

Self-directed adult-learning is the second instructional

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strategy utilized in the REIT program. Chickering and Claxton (1981) suggest that fostering competence requires that the learning process involve participants in: 1) immediate concrete experiences; 2) observing and reflecting on the experience from different perspectives; 3) forming generalizations or abstract concepts, and 4) using these concepts to solve problems and make decisions. The REIT program actively links learning to daily living by requiring students to provide respite and intervention services directly to young children with disabilities and their families; provides and structures in opportunities for self-evaluation throughout all of the activities, assignments, and experiences; and structures opportunities for the learner to establish supportive relationships with peers and other professionals. In their courses, students develop Individualized Student Learning Plans that identify their strengths as students, their areas of concerns, specific competencies that they feel they are strong in, and specific competencies that they want to strengthen. In collaboration with the course facilitator, students identify areas of focus for projects and assignments.

Problem-solving:

A third REIT instructional strategy is problem-solving, the process of resolving unsettled matters, of finding an answer to a difficulty. Because problem-solving is a skill that is not well honed in most professionals (Johnson & Johnson, 1987) but will be essential for rural early interventionists who must often work in isolation, REIT emphasizes the following steps in problem-solving in the context of both group and independent student activities: 1) stating problems clearly; 2) getting the needed information; 3) finding any gaps and discrepancies in the information gathered, and filling or resolving these; 4) communicating with others about the problem and possible solutions; 5) thinking about and testing alternative strategies and choices; and 6) creating a climate that is supportive, trusting, and cooperative.

In order to help early interventionists to sharpen their problem-solving skills the REIT program provides students with a variety of opportunities throughout their training that enable them to practice and refine their problem-solving abilities in a variety of contexts and situations, and with a variety of people. REIT student teams are given a variety of problems to solve, which may involve vignettes, case studies, and problems that the students face in their Respite Care and practical applied experiences. Specifically identified general and rural competencies provide the foundation for the design of the problems, vignettes, or case studies.

Cooperative learning:

A fourth instruction strategy in the REIT program is the use of cooperative learning techniques. Cooperative learning is the instructional use of small groups so that learners work together to maximize their own and each other's learning. Johnson, Johnson, and Holubec (1990) contend that

> *cooperative learning is indicated whenever the learning goals are highly important, mastery and retention is important, the task is complex or conceptual, problem-solving is desired, divergent thinking or creativity is desired, quality of performance is expected, and higher level reasoning strategies and critical thinking are needed (p. 31).*

Further, cooperative learning involves positive interdependence of group members; face-to-face interaction, within which group members promote each other's learning and success; use of cooperative skills (interpersonal and small group skills); individual accountability, and group processing regarding how well the group functioned.

Cooperative learning not only facilitates the learner's initial acquisition of concepts and skills, but also contributes to the application of that learning in other situations. The importance of cooperative learning for skill acquisition and transfer has been noted by several researchers. Johnson, Johnson, and Holubec (1990) outline benefits of cooperative learning identified by researchers: 1) more achievement, more higher-level reasoning, more frequent generation of new ideas and solutions and greater transfer of what was learned; 2) greater social support and more positive interpersonal relationships among learners; 3) greater perceived likelihood of success in the learning situation and increased motivation to learn; 4) greater cognitive and affective perspective taking; and 5) higher levels of self-esteem. Since the delivery of early intervention services has many of the characteristics described by Johnson, Johnson, and Holubec (e.g., is a complex process that requires problem-solving and creativity; requires critical thinking and reasoning; demands high quality performance of professionals), the application of cooperative learning methods to preservice training with early intervention competencies is warranted. Experience with cooperative learning will help students in working with and learning from their colleagues throughout their careers.

The Rural Early Intervention Training Program uses cooperative methods in structuring the assignments, applied practical experiences, and practicum. Students are placed in teams of six that remain the same throughout the semester. Teams (at times with a faculty supervisor mediating) are required to work on resolving conflicts that arise (just as in the real world, students can't change members of a team because they don't get along with them). Each of the teams consists, at a minimum, of a student who is a parent, students from various disciplines (social work, psychology, education, communication studies, nursing, early childhood education), and an upper-level senior or graduate student. Teams are required to change configurations every semester

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(because interventionists in rural areas will often work on a variety of teams) so that they can learn to function on and communicate with individuals with a variety of learning and communication styles.

Addressing recruitment and retention issues

REIT tackles rural personnel recruitment and retention issues through several strategies. First, we provide larger scholarships to students willing to do their practicum experience in the more rural, remote areas of the state. Second, we use local Child and Family Services Provider staff (Part H early intervention service provider agencies in Montana) to recruit high school students and post-secondary students from their local area who attend local and state universities, colleges, and vocational training programs in health, education, and human services fields. Furthermore, REIT program staff developed an outreach/off-campus component which provides early intervention training to individuals who have a degree in a health, education, or human services field, but need further training in providing services to infants and toddlers with disabilities and their families. The off-campus portion of REIT enables the individual who currently lives and/or works in a rural, remote area to remain in her locale and even in her current job, while taking courses by correspondence. The off-campus training provides:

1) learning modules that delineate the competencies to be learned and include audiotapes of on-campus lectures, copies of all readings required for on-campus students, assignments, quizzes, and exams;

2) a practical applied experience in a setting with young children and their families for a minimum of two hours per week (e.g., Head Start program, early intervention program, day care center, day care home);

3) a paid supervisor in or near the student's locale to supervise and evaluate the off-campus student's practical applied experience and to serve as a resource/support person;

4) a toll-free number that students may use to contact university staff with questions, comments, concerns;

5) periodic phone conferences with university staff and other students involved in the off-campus courses;

6) scholarships that cover tuition and books; and

7) support staff to help with library searches and research.

Conclusion

Competent early intervention will in many ways look the same in a remote rural area as it does in a metropolis (see the general early intervention competencies in Division for Early Childhood's White Paper [McCullom et. al., 1989]). However, some specific characteristics of rural and remote areas require the development, implementation and evaluation of specific models of training for the delivery of early intervention services and supports in this context. Programs preparing early interventionists to work in rural environments must be responsive to and prepare students with not only general early intervention competencies, but also additional competencies specific to rural, remote areas. Rural preservice training programs should provide incentives to train to work in rural, remote areas. Their instructional strategies and techniques should enable students to gain the knowledge and practice the skills they will need to be effective with families and other professionals in rural areas.

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Videotapes

Family Violence in America: The Power Within. Distributed by Altschul Group Corporation, 1560 Sherman Avenue, Suite 100, Evanston, IL 60201, tel: 800/323-9084. Four 22-minute tapes, each $295.

This series examines the family's role in perpetuating violence and its potential for healing. Dramatic vignettes and interviews are used to illuminate the roots of violence, generational patterns, and the complex feelings of trauma, shame, and lost innocence caused by violence. *Child Abuse* shows how patterns of family abuse set the stage for children to become either perpetrators or victims of abuse in later life. Vignettes illustrate counseling with victims of abuse and explore the complex motivations of the perpetrator of abuse. *The Fear of Anger* offers examples of appropriate expression of anger and teaches healthy anger management designed to replace aggressive behaviors with healthy communication among family members. *Conflict Resolution* offers guidelines for conflict resolution designed to minimize the possibilities for violence. *The Horror and the Healing* presents stories of people who have endured domestic violence, explores techniques for healing individuals and families, and emphasizes the importance of breaking the cycle of abuse.

Siblings: Why Do They Fight and What Can We Do About It? Produced by the Association of Child Development Specialists and the Ruth Pearce Fund for Therapeutic Companions. Distributed by Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401, tel: 800/405-8942. 60 min. $40.

In this tape, designed for parents, parent groups, and professionals, Ruth Pearce, a child development specialist, speaks to a group of parents and professionals about brothers and sisters and the rivalry that can develop between them. In this lecture, followed by questions from the audience, she documents evidence of sibling rivalry throughout history and discusses why sibling rivalry is so intense and of such concern in American middle-class culture. She identifies developmental issues that affect how children feel about their brothers and sisters and offers techniques that can help parents manage the sibling rivalry their children experience.

The Importance of Establishing Boundaries and Setting Limits for Young Children. Produced by the Association of Child Development Specialists and the Ruth Pearce Fund for Therapeutic Companions. Distributed by Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401, tel: 800/405-8942. 60 min. $40.

This videotaped lecture to parents and professionals by Ruth Pearce, a child development specialist, begins with a definition of boundaries — how we live by them and their presence in all relationships. Ms. Pearce gives

examples of typical behavior patterns of young children that challenge boundaries, as well as parents' confidence in their ability to maintain them. The presentation, developed for parents, parent groups, and professionals, explores the developmental consequences of parents saying "yes" or "no" to their children, and the angry response that can follow a "no." She discusses what is required of parents as they discipline their children and offers strategies that can support the ongoing process.

Publications

The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy (1995) - Daniel N. Stern (Basic Books, 10 East 53rd Street, New York, NY 10022-5299) $35.00.

The "motherhood constellation," Daniel Stern suggests, is a new and unique psychic organization specific to mothers in developed, Western, postindustrial societies. When a woman becomes a mother in our culture, she faces key questions: Can she maintain the life and growth of the baby? Can she emotionally engage with the baby in her own authentic manner, and will that engagement assure the baby's psychic development toward the baby she wants? Will she know how to create and permit the necessary support system to fulfill these functions? Will she be able to transform her self-identity to facilitate these functions? Stern argues that a therapist working with a new mother can appropriately be like a "good grandmother" — active, making home visits, giving developmental advice, and more focused on assets, capacities, and strengths than on pathology and conflicts.

As he develops a unified view of parent-infant psychotherapy, Stern describes in detail the elements of any parent-infant system: the parents' representations of the relationship with their baby, the overt interactions occurring between parent(s) and infant, the infant's experiences and representations of these interactions, and the place of the therapist.

Exploring Rural Medicine: Current Issues and Concepts (1994) - Barbara P. Yawn, Angeline Bushy, and Roy A. Yawn, editors (SAGE Publications, Inc., 2455 Teller Road, Thousand Oaks, CA 91320) $24.95.

Physicians in rural settings are often called upon to treat a wide range of problems for which they have limited training due to a lack of technological, nursing, and consultant resources. This volume is designed as a reference to help health practitioners who face uniquely rural concerns. Topics addressed include labor and delivery crises, stabilization and transport of the ill newborn, managing bronchopulmonary dysplasia after the infant goes home, recognition and evaluation of child abuse, adolescent pregnancies in rural America, common mental health problems, environmental hazards, women's health issues, health maintenance strategies and barriers, patient education, and quality assessment.

Effective Communication in Multicultural Health Care Settings (1994) - Gary L. Kreps and Elizabeth N. Kunimoto (SAGE Publications, Inc., 2455 Teller Road, Thousand Oaks, CA 91320) $16.95.

Developing effective multicultural relations between culturally unique participants in the modern health care system is a prerequisite to effective health care delivery. Yet members of health care teams are likely to have very different, and often conflicting, orientations to providing health care. The authors offer 92 suggestions for developing multicultural health communication competencies and promoting public health. These include recognizing that health care treatment must attend to both the physical and symbolic aspects of illness to be effective, helping consumers of health care overcome the limitations of the "sick" role, deemphasizing status differences and distance between providers and consumers, and enhancing interpersonal communication over the telephone by emphasizing appropriate nonverbal components of speaking, such as pitch, loudness, conversational speed, and voice quality to influence the feelings and attitudes of listeners.

Beating the Devil Out of Them: Corporal Punishment in American Families (1994) - Murray A. Straus (Lexington Books, 866 Third Avenue, New York, NY 10022) $24.95.

Corporal punishment, this volume argues, can tremendously influence the psychological development of chil-

Call for presentations

Head Start's Third National Research Conference, which will be held June 20-23, 1996 in Washington, D.C., invites proposals for symposia emphasizing the study of children and families within their social/cultural context and poster presentations of research in progress, recently published or unpublished research, or a synthesis of findings already in the literature. Topics may include infants and toddlers, normative child development, children with special needs, quality issues, physical and mental health, the family in the community, family support and self-sufficiency, cultural and linguistic diversity, stressors, new approaches to the study of children, families, and communities, and applications from programs in other countries. **Proposals must be postmarked no later than June 30, 1995.** For proposal forms, contact Dr. Faith Lamb Parker, Project Director, tel: (212) 304-5251; fax: (212) 305-7024; e-mail: flp1@columbia.edu.

dren because it often begins in infancy (before age one), it happens very frequently — probably every day for many toddlers, and it continues through the preschool years when the deepest layers of personality are presumably being formed. For at least half of all American children, it continues into the teenage years. Murray Straus suggests that corporal punishment may serve to legitimize other forms of violence. Used by authority figures who tend to be loved or respected as a way to achieve a morally correct end, it carries the (unintended) message that if someone is doing something outrageous and other methods of getting the person to listen to reason have failed, physical violence is acceptable. Straus suggests that children who are spanked are from two to six times more likely to be physically aggressive, to become juvenile delinquents, to use physical violence against their spouses, to have sadomasochistic tendencies, and to suffer from depression.

Improving Child Care in Rural Areas: Promising Practices and Strategies (1994) - Prepared by Macro International Inc. for Child Care Division, Administration for Children and Families, Department of Health and Human Services (photocopies available from ZERO TO THREE, 1-800-899-4301) $2.50 plus $2.50 shipping and handling.

Rural parents with young children have complex child care needs, due to long and irregular hours, commuting and transportation problems, and decline of extended families. Low population density and the lack of private investment limit the child care supply in rural areas. This study of innovative approaches to rural child care service delivery undertaken by North Carolina, Montana, Oregon, and Kentucky revealed a number of lessons from these states' experience: 1) Family child care may be the most effective way to increase the supply of rural child care; 2) Involving existing community organizations (e.g., churches) builds trust; 3) Supporting resource and referral agencies can help improve rural child care; 4) Financial incentives can overcome barriers to training in rural communities; 5) Assuring that training for child care is accessible requires creative solutions (e.g., telecommunications, home-study programs); and 6) Rural child care can both contribute to and benefit from broader economic strategies.

Environments of Birth and Infancy (*Children's Environments*, Volume 11, Number 2, June 1994) - Roger A. Hart, Sheridan Bartlett, and Louise Chawla, editors (Journals Promotions Department, E. & F.N. Spon, 1 Penn Plaza, 41st Floor, New York, NY 10119) $25.00.

This special issue of *Children's Environments* on infancy and childbirth emphasizes the play between the baby and the material world. The editors note:

From Peruvian manta pouch to neonatal intensive care unit, we create extraordinary environments to buffer our infants from stress; and in their very sleeping arrangements we begin to influence how they will respond throughout life to their social world and its demands.

Articles in this issue examine primarily environments of sleep in various cultures and on institutional settings for both birth and infant care. Contributors include, among others, Thomas Anders, T. Berry Brazelton, Tiffany Field, Louise Hainline, Thelma Harms, Chisato Kawasaki, J. Kevin Nugent, and Edward Z. Tronick.

Essential Allies: Families as Advisors (1994) - Elizabeth S. Jeppson and Josie Thomas (Institute for Family-Centered Care, 7900 Wisconsin Avenue, Suite 405, Bethesda, MD 20814) $10.00.

This publication is designed as a practical manual for service providers on involving families as consultants and advisors in policy and program development. (A companion document for families presents information and resources on serving in advisory roles.) Suggested guidelines for family participation at the policy and program level include, among others: using innovative ways to identify and recruit families; providing training and support to both families and professionals; addressing logistical barriers comprehensively and creatively; and being aware of parental burn-out. The manual includes illustrations of how hospitals, state agencies, community programs, and universities have fostered family/professional collaboration in policy and program development (with particular emphasis on involving families who have been traditionally underrepresented in policy-making activities) as well as checklists, worksheets, and sample documents.

Toward Systemic Reform: Service Integration for Young Children and Their Families (1995) - Sharon L. Kagan, Stacie G. Goffin, Sarit A. Golub, and Eliza Pritchard (National Center for Service Integration, 5111 Leesburg Pike, Suite 702, Falls Church, VA 22041) Free of charge.

Despite a history of political, ideological, and practical obstacles, service integration, the authors of this study argue, is coming of age as a strategy for systemic reform. This study of service integration efforts in four states (Colorado, Florida, Indiana, and Oregon) identifies four functions of service integration: bringing together previously unconnected services; overturning past practice, policy, or bureaucracy; creating mechanisms that work to promote and sustain integrative strategies; and changing relationships for and among people and institutions. Six elements emerged as critical to the creation of comprehensive service integration efforts which fulfill all four functions: 1) within- and across-domain integration; 2) multiple approaches; 3) state and local level components; 4) articulated, bi-directional state/local highways; 5) creative, broad-based involvement; and 6) specification of targeted accomplishments. The study draws specific implications for action by practitioners, policy makers, and researchers.

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Virginia A. View and Kim J. Amos
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Report of a five-year study, funded by the Maternal and Child Health Bureau Division for Children with Special Health Care Needs (Grant No. MCJ-115041), of how communities in Colorado, Illinois, Indiana, Rhode Island, Texas, and Washington try to overcome the barriers of categorical funding and fragmented services to meet the needs of infants, toddlers, and their families

A Welcome for Every Child: Care, Education, and Family Support for Infants and Toddlers in Europe

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Two internationally recognized researchers look at how Denmark, France, Italy, England, and Finland guarantee quality child care choices for families with infants and toddlers and mobilize communities to support the cognitive and social development of children under three.

Caring for Infants and Toddlers in Violent Environments: Hurt, Healing and Hope

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Joy D. Osofsky and Emily Fenichel, editors, with the ZERO TO THREE Violence Study Group
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